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Nancy A. Moore

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AIDS DISCRIMINATION UNDER THE REHABILITATION ACT: WHEN A PHYSICIAN REFUSES TO TREAT, WHO IS LIABLE?

INTRODUCTION

AIDS is the commonly recognized acronym for the disease called Acquired Immunodeficiency Syndrome. Scientists have named the virus that causes AIDS the "human immunodeficiency virus" (HIV). The impact of HIV infection has become a major worldwide public health issue. The Centers for Disease Control (CDC) estimate that by the end of 1992, the number of systemic AIDS cases will reach 365,000, with an expected 80,000 newly diagnosed cases in that year alone. During 1992, the cost of medical care of AIDS patients will range from $5 billion to $13 billion. Although AIDS began as a medical problem, it has become a legal problem of enormous dimensions.

One legal problem related to AIDS is that some health care providers have refused to care for persons infected with HIV out of fear that they will contract the infection from these patients. Such refusals raise difficult ethical and legal dilemmas.

This Comment addresses the issue of a physician's refusal to treat an HIV-positive patient, as well as a hospital's potential liability for refusing to treat. First, the Comment examines the nature of the AIDS disease and the risk of occupational infection to health care workers. Next, it addresses the Rehabilitation Act of 1973 and its prohibition against discrimination on the basis of disability in feder-

1. The virus has also been called "human T-cell lymphotrophic virus type III (HILV - III)" caused by a "lymphadenopathy-associated virus (LAV)." Robert M. Jarvis et al., AIDS Law in A Nutshell 6 (1991).
3. "Systemic" is defined as "of or pertaining to the whole body, rather than to a localized area or regional portion of the body." Mosby's Medical & Nursing Dictionary 1050 (Laurence Urdang & Helen H. Swallow eds., 1983).
4. Hermann & Schurgin, supra note 2, § 1:03.
5. Id.
6. Jarvis et al., supra note 1, at 3.
ally funded programs. The development of AIDS as a disability under the Act is examined in this context. In order to identify whether a hospital may be liable for the acts of its physicians, the Comment discusses the common law doctrine of respondeat superior. The Comment then addresses vicarious liability as it applies to hospitals, under the doctrines of respondeat superior and ostensible agency. Additionally, it examines the applicability of respondeat superior to actions brought under section 504 of the Rehabilitation Act. The Comment applies these areas of law to the situation in which a physician refuses to treat a patient because the patient has tested positive for the AIDS virus. Finally, the Comment addresses the hospital's potential vicarious liability for the physician's actions.

This Comment will demonstrate that the parameters of the physician's and hospital's liability will depend on several factors, including the physician's relationship with the hospital, the existence or lack of an independent practice, and the degree of control the hospital exerts over the physician.

I. BACKGROUND

In order to understand why a health care provider may refuse to treat an AIDS patient, it is important to understand the nature and effects of the disease.

A. Clinical Description of AIDS

Upon entering the blood stream, the AIDS virus begins to attack certain white blood cells (T-lymphocytes), which are an essential part of the human immune system. As a result, the immune system becomes impaired. Individuals with AIDS become susceptible to a variety of opportunistic infections and malignant conditions that generally do not affect people who have normal resistance to disease.


10. An opportunistic infection is an infection caused by organisms which normally do not cause disease in a healthy individual, but are disease causing in a host whose resistance has been weakened. MOSBY'S MEDICAL & NURSING DICTIONARY, supra note 3, at 770.

11. Wasson, supra note 9, at 223.
HIV can be transmitted through the exchange of certain kinds of bodily fluids.\(^\text{12}\) It may be contracted by: 1) sexual intercourse involving the exchange of blood, semen, or vaginal secretions; 2) sharing unsterilized syringes; 3) receipt of donated blood, semen, breast milk, or human organs; and 4) child birth or breast feeding of an infant.\(^\text{13}\) Casual contact, such as shaking hands, hugging, kissing, sharing eating utensils, and using common bathroom facilities, will not transmit the virus.\(^\text{14}\)

Once an individual is infected, the disease may progress within the individual in several ways: testing HIV-positive, the appearance of symptoms, and AIDS.\(^\text{15}\)

\section*{1. Testing HIV-Positive, But Showing No Symptoms}

The majority of people who become infected develop antibodies to the virus but do not experience any immediate symptoms.\(^\text{16}\) However, a number of individuals will experience a condition similar to mononucleosis at the time they initially become infected with HIV.\(^\text{17}\) Those who experience some symptoms, and the majority who never experience any symptoms, typically enter an asymptomatic carrier state, in which evidence of the HIV infection may be found upon laboratory testing.\(^\text{18}\)

The length of time that an individual remains asymptomatic is presently estimated to be seven to ten years.\(^\text{19}\) Following the asymptomatic period, one or more symptoms will begin to appear.\(^\text{20}\)

\section*{2. Appearance of Symptoms or AIDS-Related Complex (ARC)}

ARC is a condition in which the patient tests HIV-positive but has a specific set of clinical symptoms that are less severe than those found in full-blown AIDS.\(^\text{21}\) Signs and symptoms of ARC include

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    \end{itemize}
\end{itemize}
swollen lymph nodes, fatigue, skin rash, fever, diarrhea, night sweats, and weight loss. Some patients also develop infections suggestive of an impaired immune system that are not necessarily life-threatening, such as oral candidiasis and herpes zoster.

3. Acquired Immunodeficiency Syndrome (AIDS)

In addition to the generalized symptoms mentioned previously, serious opportunistic diseases may attack individuals with HIV because of their depressed immune systems. The term “AIDS” is reserved for individuals who have developed at least one life-threatening clinical condition that is clearly linked to HIV-caused immunodeficiency. These include conditions such as Kaposi’s sarcoma (KS), pneumocystis carinii pneumonia (PCP), and dementia. Opportunistic infections are the major cause of death in HIV-infected patients.

4. Current State of the AIDS Epidemic

America’s AIDS epidemic has entered what scientists call a “mature” phase: a long-term presence with a slowly shifting profile. In the late 1970s and throughout the 1980s, the virus spread rapidly among gay men and intravenous drug users. Today, an estimated one million living Americans carry the HIV virus. Of these individuals, 200,000 have developed full-blown AIDS, and more than 125,000 have died. According to rough estimates by the CDC, 50,000 or more people become infected with the virus each year.

On November 7, 1991, Magic Johnson, “one of the most popular...
and accomplished players in basketball history," announced that he was infected with the HIV virus and would be retiring from the Los Angeles Lakers. He was quoted as saying, "I think sometimes we think, well, only gay people can get it — 'It's not going to happen to me.' ... I am saying that it can happen to anybody." Magic Johnson's honest admission of his illness and his willingness to discuss it have pleased educators and health planners. Legislative leaders who recently sought to cut AIDS education budgets are now exploring ways to attack the problem more aggressively. Dr. Karen Hein, the director of the adolescent AIDS program at Montefiore Medical Center in the Bronx, stated, "At this point, and for the first time, the virus has become an all-American problem."

Because AIDS is affecting more segments of the population and is spreading rapidly, accessibility of medical care for persons with AIDS is critical. An important factor related to the accessibility of treatment is the attitude of the individual who provides that care. A major problem confronting the medical field today involves care-givers becoming fearful of contracting the disease from patients.

B. Health Care Workers' Occupational Risk of Exposure to HIV

In the face of the AIDS epidemic, some health care workers refuse to care for HIV-positive patients for fear of becoming infected themselves. However, according to much scientific evidence, many health care workers are at low risk of acquiring HIV from occupational exposure to patients. A puncture wound caused by a contaminated needle constitutes the most common risk to medical workers. Puncture wounds may occur in a variety of circumstances, such as improper disposal of used syringes, disposal of used syringe containers which are overly full, and attempts at recapping used syringes. See Lo, supra note 7, at 368-69.
sion following needlestick exposures to HIV-infected patients' blood is less than 1.0%. Studies of work-related exposures indicate that only 0.1% to 0.25% of the exposures will seroconvert following a needlestick injury, and the level of risk associated with the exposure of nonintact skin or mucous membranes is even less likely. Therefore, the occupational risk of HIV is low but still exists. The overall risk of HIV transmission, however, for those health care workers who are more frequently exposed to blood or other bodily fluids is more uncertain. Such health care workers include persons working in emergency rooms, delivery rooms, and operating rooms where they are more likely to suffer needlesticks and cuts. Health care workers such as general internists, psychiatrists, and administrators who do not risk needlesticks and cuts are at a much lower risk of contracting the HIV virus.

Even though occupationally acquired HIV is rare, the risk is frightening nonetheless. If contracted, the HIV infection is most likely fatal, as there is no known vaccine or cure for the infection. Furthermore, precautions recommended by the CDC to reduce the risk of occupational HIV infection do not fully protect against some potential routes of transmission, such as needlesticks or cuts.

40. "Seroconversion" is a term used to indicate the fact that an individual has converted from seronegative (indicating no infection) to seropositive (indicating infection). See Lo, supra note 7, at 267 n.1.

41. Gramelspacher & Siegler, supra note 38, at 389.

42. "Nonintact skin" refers to skin whose integrity is broken or impaired. "Mucous membranes" line the cavities or canals of the body that open to the outside, such as the linings of the mouth, the nose, the eyelids, and the genitourinary tract. Viruses may enter the body through a break in the skin or through the mucous membranes. Mosby's Medical & Nursing Dictionary, supra note 3, at 702, 1138.

43. Gramelspacher & Siegler, supra note 38, at 389.

44. Lo, supra note 7, at 368.

45. Id.

46. Id.

47. Id. at 369. Although in the early stages of the disease, symptoms may be nonexistent or not life threatening, eventually the disease weakens the immune system to the point that death results from opportunistic infections. See supra notes 24-27 and accompanying text.

48. Lo, supra note 7, at 369.

49. Id. at 368. The CDC guidelines suggest that health care workers protect themselves with gloves, masks, goggles, or gowns whenever they risk exposure to blood or body fluids. Id.

There are additional reasons for the reluctance or unwillingness of some health care workers to treat patients with HIV infection and AIDS. Besides fear and the perception of risk, prejudice and reluctance to care for certain types of patients (including homosexual patients and intravenous drug users) are two reasons for such refusal.\textsuperscript{50} Traditionally, the medical profession has emphasized the principle of benefitting the patient rather than focusing on the medical practitioners' interests.\textsuperscript{51} In this sense, altruism rather than self-interest should be the controlling motivation of those practicing medicine.\textsuperscript{52} However, this ideal of altruism may be viewed by some as controversial when applied to epidemics.\textsuperscript{53}

In response to this issue, most major medical organizations have issued policy statements addressing the AIDS epidemic.\textsuperscript{54} In No-
vember of 1987, the American Medical Association (AMA) stated, "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive [for the AIDS virus]."5 The Texas Medical Association and the Arizona State Board of Medical Examiners took a different stance.6 They adopted policies which allowed a physician to refuse to treat persons infected with the AIDS virus only if they referred the patient to another physician.57

In January of 1988, the AMA conducted a national survey on physicians' attitudes about AIDS and HIV-infected individuals, as well as related practice issues.58 The survey was intended to gather information for future educational programs about the disease and coordinating health services and providers so that an integrated system of health care delivery is created wherein emergency departments play a vital and targeted role.


The American College of Surgeons has issued this statement:
1. Surgeons have the same ethical obligations to render care to HIV-infected patients as they have to care for other patients.
2. Surgeons should utilize the highest standards of infection control, involving the most effective known sterile barriers, universal precautions, and scientifically accepted infection control practices. This practice should extend to all sites where surgical care is rendered.


The American Dental Association has issued this advisory opinion:

A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested, in such instances, should be made on the same basis as they are made with other patients, that is, whether the individual dentist believes he or she has need of another's skills, knowledge, equipment or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment.


56. Taunya L. Banks, *AIDS and the Right to Health Care, 4 ISSUES L. & MED. 151, 152 (1988). The Chairman of the Texas Association's Board of Counselors said, "We didn't agree that a physician who diagnoses AIDS is mandated to treat the patient. I don't think it can be called discrimination when it's a matter of a guy laying his health and career on the line." Lo, *supra* note 7, at 369-70.


58. L.B. Bresolin et al., *Attitudes of U.S. Primary Care Physicians About HIV Disease and AIDS, 2 AIDS CARE 117 (1990).*
to assist the Association in formulating appropriate policies. The AMA conducted telephone interviews with five hundred randomly selected primary care physicians. One set of questions inquired into the depth of the physicians' concerns about the personal risk of contracting AIDS. The survey discovered that physicians are quite concerned about contracting the HIV virus, and that their personal anxiety levels are significant. Fifty-six percent of responding physicians feared that they could become HIV-infected in the course of their medical practices. Approximately 66% reported that their families would worry if they treated more patients with the HIV virus, and 76% stated that their staffs would worry. Eighty-three percent stated that they observed fear among their professional colleagues. However, despite this fear, 70% concluded that they had an ethical duty to treat HIV-infected patients.

It is important to recognize that some contemporary physicians have flatly rejected professional codes or pronouncements that require them to care for patients infected with HIV. This kind of rejection may be more prevalent among those who perceive themselves to be at the highest risk of occupational HIV infection, such as vascular surgeons. Some health care workers in the high risk category complain that those espousing a duty to treat are not themselves at personal risk.

C. The Doctor-Patient Relationship

In addressing the issue of whether a physician has an obligation to treat a patient, it is important to understand how a physician-patient relationship is created. The doctor-patient relationship is based on the mutual consent of each party and may arise from an
express or implied contract.70 Because of the consensual nature of the relationship, a physician has no legal obligation71 to accept any patient for treatment.72 However, once a physician-patient relationship is established, it continues until: “(1) it is terminated by mutual consent; (2) it is terminated by the patient; (3) the physician’s services are no longer needed; or (4) the physician withdraws after reasonable notice to the patient.”73 Once the physician has begun treating the patient, he may not simply abandon the patient without first ensuring that alternative medical care is available.74

In this context, a problematic situation may arise. A physician may begin to treat a patient without being aware of the patient’s HIV status. In the course of treatment, the physician may then discover that the patient is HIV positive. The necessary treatment may include procedures (i.e., surgery) that the physician perceives as putting him at risk of becoming infected. If there is not adequate time to give reasonable notice of withdrawing, or if the physician is not able to ensure alternative medical care, the issue arises whether the physician must continue to treat the patient. Most medical association position statements indicate there is an ethical obligation to continue treatment. Furthermore, antidiscrimination statutes, such as section 504 of the Rehabilitation Act of 1973,75 may impose a legal duty to care for seropositive persons.

D. The Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against individuals with disabilities in federally assisted programs or activities.76 Congress patterned the language of section 504 after Title VI of the Civil Rights Act of 1964.77 Indeed, negative attitudes toward the disabled have been compared to attitudes

70. Id. at 376.
71. However, an ethical obligation to accept a patient may still exist. See supra notes 54-57 and accompanying text (discussing the stance taken by various associations regarding the ethical duty of health care workers to care for HIV-infected patients).
72. Lo, supra note 7, at 376.
73. Id. (quoting George J. Annas, Legal Risks and Responsibilities of Physicians in the AIDS Epidemic, HASTINGS CTR. REP., Apr.-May 1988, at 26, 30).
74. Id.
76. Id.
toward underprivileged minority groups. The language and history of section 504 show Congress’s desire to provide the disabled, like underprivileged minorities, with the guarantee of equal opportunity.

Section 504 provides in pertinent part: “no otherwise qualified individual with handicaps shall, solely by reason of her or his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” The Act defines “program or activity” as “all of the operations of an entire corporation, partnership, or other private organization or an entire sole proprietorship which is principally engaged in the business of providing education, health care, housing, social services, or parks and recreation; any part of which is extended federal financial assistance.” Thus, the Act includes federally financed health care facilities within its definition of “program or activity.”

The Act defines “individual with handicaps” as “any person who (i) has a physical or mental impairment which substantially limits one or more of such person’s major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment.”

80. 29 U.S.C. § 794(a) (1985 and Supp. 1991). The regulations promulgated under the Act define “federal financial assistance” as “any grant, loan, contract (other than a procurement contract or a contract of insurance or guaranty) or any other assistance in the form of: 1) funds; 2) federal personnel services; or 3) real and personal property at less than fair market value. 45 C.F.R. § 84.3(h) (1991).
82. Id.
(A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; repro-

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Since its enactment in 1973, Congress has expanded the protection of section 504 to maximize the number of disabled individuals who fall within its coverage. As originally enacted, the definition of "handicapped individual" reflected the statute's focus on vocational rehabilitation. The original definition included only those whose disability limited their employability, and those who could be expected to benefit from vocational rehabilitation. After reviewing the Department of Health, Education and Welfare's attempts to devise regulations to implement the Act, Congress concluded that the original definition of "handicapped individual" was too narrow to address the range of discriminatory practices in housing, education, and health care programs. Such discrimination evolved out of stereotypical attitudes and ignorance about the disabled. In 1974, Congress expanded the definition to its current form. The Supreme Court has interpreted the term "handicapped individual" in several cases, including *Arline* and *Baxley*. The Supreme Court has defined "handicapped individual" to include anyone who has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and can reasonably be expected to benefit in terms of employability from vocational rehabilitation services. The definition has been amended over time to include individuals who have recovered from a handicap, as well as those who were classified as handicapped but may still be in need of protection. The Supreme Court has noted that the definition must be interpreted broadly to ensure that the rights of disabled individuals are protected.
Court has described the amended definition as "reflect[ing] Congress' concern with protecting the disabled against discrimination stemming not only from simple prejudice, but also from 'archaic attitudes and laws' and from 'the fact that American people are simply unfamiliar with and insensitive to the difficulties confront[ing] individuals with handicaps.'"989

It is noteworthy that the Rehabilitation Act's coverage extends only to programs or activities receiving federal financial assistance. Nevertheless, Congress also sought to protect the disabled in situations outside the reach of the Rehabilitation Act. To achieve this goal, the Americans with Disabilities Act of 1990 was passed.

1. The Impact of the Americans with Disabilities Act upon the Rehabilitation Act

The Americans with Disabilities Act of 1990 (ADA)96 was signed into law on July 26, 1990. The effective dates of its sections and subsections range from July, 1990 to July, 1992.91

The ADA prohibits discrimination against individuals with disabilities.97 Like section 504's definition of an individual with a handicap, the ADA defines a "disability" as: "A) a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual; B) a record of such an impairment; or C) being regarded as having such an impairment."98 However, the ADA explicitly excludes from the definition any individuals who currently use illegal drugs.94 In addition, it amends section 706, to which the Rehabilitation Act refers for its definition of "individual with handicaps," to reflect this exclusion of current illegal drug users.99 However, section 706 explicitly states that for purposes of

92. Id. § 12101(b).
93. Id. § 12102(2).
94. Id. § 12210.
95. 29 U.S.C. § 706(8)(c)(i) (Supp. 1990). The statute states: "For purposes of subchapter V of this chapter, the term 'individual with handicaps' does not include an individual who is currently engaging in the illegal use of drugs, when a covered entity acts on the basis of such use." Id.
programs and activities providing health services, an otherwise qualified individual will not be excluded because of his current use of illegal drugs.\(^9\)

An important difference between the Rehabilitation Act and the ADA is the scope of the two statutes. The Rehabilitation Act applies to "any program or activity receiving Federal financial assistance."\(^9\)\(^7\) Enforcement of the Rehabilitation Act is premised upon federal involvement in the programs and activities covered by the statute.\(^9\)\(^8\) By contrast, Congress's power to enact the ADA comes from its power to enforce the Fourteenth Amendment and to regulate commerce.\(^9\)\(^9\) Therefore, unlike the Rehabilitation Act, the ADA may be enforced against entities that do not receive any type of federal financial assistance.

The ADA is composed of four titles (subchapters). Title I addresses employment,\(^1\)\(^0\) Title II focuses on public services,\(^1\)\(^1\) and Title III covers public accommodations and services operated by private entities.\(^1\)\(^2\) Title III lists twelve categories of establishments that are considered public accommodations, including doctors' offices and hospitals.\(^1\)\(^3\) Finally, Title IV covers miscellaneous provisions.\(^1\)\(^4\)

Under Title III, "[n]o individual shall be discriminated against on
the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.\textsuperscript{100} Therefore, in the context of the provision of health care, any person who owns a doctor’s office or hospital, leases (or leases to) a doctor’s office or hospital, or operates a doctor’s office or hospital, is subject to the statute’s prohibitions.\textsuperscript{100}

The ADA provides a new approach for eliminating discrimination against individuals with disabilities and may be applied in situations where the discriminating entity does not receive any type of federal funding. It will take time, however, to determine the manner in which the courts will interpret the statute and its provisions. Meanwhile, the Rehabilitation Act remains a viable and tested means of providing a cause of action to individuals who have been discriminated against on the basis of their disability.\textsuperscript{107} Together these two statutes should provide a comprehensive approach toward achieving the national goal of equality of opportunity and participation for disabled individuals.\textsuperscript{108}

2. \textit{A Cause of Action under the Rehabilitation Act}

A violation of the Act gives rise to two important rights that a plaintiff may exercise in seeking complete vindication: (1) he may bring a private cause of action, and (2) he may seek damages as a remedy.

a. Existence of a private cause of action

A private right of action allows an individual to bring suit for violation of a government statute. One benefit of this approach is that the individual does not have to wait for the government to initiate prosecution of the suit. In \textit{Pushkin v. Regents of the University}
of Colorado," the Tenth Circuit addressed the issue of whether a private right of action exists under the provisions of the Rehabilitation Act and held that such a right does exist. In this case, Dr. Pushkin was a medical doctor who alleged that he was denied admittance to the University of Colorado Psychiatric Residency Program because he suffered from multiple sclerosis. Dr. Pushkin could not walk or write, and was confined to his wheelchair. The district court ruled in favor of Pushkin, granting him an injunction and directing that he be admitted to the program. The University appealed, arguing that no private cause of action existed under section 504.

Initially, the Tenth Circuit noted that every federal appellate and district court that had dealt with the issue held that a private right of action existed under the statute. It then looked to the United

109. 658 F.2d 1372 (10th Cir. 1981).
110. Id. at 1380.
111. Id. at 1376.
112. Id.
113. Id. Pushkin also sought money damages, but this request was denied. Id. No appeal was taken from the denial.
114. Id. at 1376-80.
115. Id. The Pushkin court cited appellate court cases from seven circuits in support of the proposition that a private cause of action exists under § 504: Kling v. County of Los Angeles, 633 F.2d 876 (9th Cir. 1980); Camenisch v. University of Tex., 616 F.2d 127 (5th Cir. 1980); Rogers v. Frito Lay, Inc., 611 F.2d 1074 (5th Cir.), cert. denied, 449 U.S. 889 (1980); NAACP v. Medical Ctr., Inc., 599 F.2d 1247 (3d Cir. 1979); Davis v. Southeastern Community College, 574 F.2d 1158 (4th Cir. 1978), rev'd on other grounds, 422 U.S. 397 (1979); Leary v. Crapsey, 566 F.2d 863 (2d Cir. 1977); United Handicapped Fed'n v. Andre, 558 F.2d 413 (8th Cir. 1977); Kampmeier v. Nyquist, 553 F.2d 296 (2d Cir. 1977); Lloyd v. Regional Transp. Auth., 548 F.2d 1277 (7th Cir. 1977). In another case, Simpson v. Reynolds Metals Co., 629 F.2d 1226, 1230 n.7 (7th Cir. 1980), the 7th Circuit left open the question of whether a private right of action should, after promulgation of regulations enacted pursuant § 504, be limited to judicial review of administrative proceedings. Pushkin, 658 F.2d at 1377. Additionally, the Tenth Circuit decided in Pushkin that a private right of action exists. Id. at 1380.

In cases subsequent to Pushkin, the remaining circuits have also recognized that a private cause of action exists under § 504: Harris v. Thigpen, 941 F.2d 1495 (11th Cir. 1991) (involving HIV-positive inmates who were handicapped within the meaning of the Rehabilitation Act and who brought an action challenging policies and procedures of the Alabama Department of Corrections); Cousins v. Secretary of the United States Dept. of Transp., 857 F.2d 37 (1st Cir. 1988) (holding that the Rehabilitation Act provision carried with it a private right of action against the federal government acting in its regulatory capacity); Hall v. United States Postal Serv., 857 F.2d 1073 (6th Cir. 1988) (holding that federal employees alleging handicap discrimination in employment may maintain private actions against employers under the Rehabilitation Act, §§ 501 and 504); Andrews v. Consolidated Rail Corp., 831 F.2d 678 (7th Cir. 1987) (recognizing that a private cause of action exists under § 504, in holding that a state statute of limitations applied to the private action); Milbert v. Koop, 830 F.2d 354 (D.C. Cir. 1987) (holding that a military exception to Title VII and the Rehabilitation Act did not apply to a commissioned officer of the United States Public Health Service and did not bar the officer from bringing suit under the
States Supreme Court for direction regarding the issue. In *Cort v. Ash*, the Supreme Court established a test for determining whether a private right of action may be inferred from a statute which does not expressly provide for such a right. The *Cort* test involved the following inquiry:

First, is the plaintiff "one of the class for whose especial benefit the statute was enacted"—that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? [Fourth], is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

The *Pushkin* court determined that the requirements of the *Cort* test were fully satisfied when applied to section 504. Therefore, a private right of action existed.

In further support of the determination that a private right of action existed, the *Pushkin* court examined the Supreme Court’s decision in *Cannon v. University of Chicago*. There, the Supreme Court stated that Title IX of the Education Amendments Act of 1972 was patterned after Title VI of the Civil Rights Act of 1964. Since Title VI creates an implied right of action for discrimination, the Court reasoned that Title IX should also be read to imply a private right of action. The *Pushkin* court decided that since section 504 was also patterned after Title VI, the same reasoning applied. In *Cannon*, the Supreme Court recognized that Title VI and Title IX sought to accomplish two purposes: “to avoid the use of federal resources to support discriminatory practices,” and “to provide individual citizens effective protection against those practices.” The Court held that a private right of action was nec-

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117. *Id.* at 78.
118. *Id.* (quoting Texas & Pac. Ry. v. Rigsby, 241 U.S. 33, 39 (1916) (emphasis supplied and citations omitted)).
119. *Pushkin*, 658 F.2d at 1378.
120. 441 U.S. 677 (1979).
122. 441 U.S. at 694.
123. *Id.*
necessary to promote the latter purpose.\textsuperscript{126} For these same reasons, the\textsuperscript{\textit{Pushkin}} court held that section 504 must be read to imply a private right of action in order for disabled individuals to have effective protection against discriminatory practices.\textsuperscript{127}

b. Standards regarding the burden of proof in a section 504 cause of action

To prevail in a section 504 cause of action, a plaintiff must successfully carry the applicable burden of proof. The\textsuperscript{\textit{Pushkin}} court identified the appropriate burden of proof in a section 504 claim, as set out by the Supreme Court in\textit{Southeastern Community College v. Davis}.\textsuperscript{128}

1) The plaintiff must establish a prima facie case by showing that he was an otherwise qualified disabled person \textit{apart from} his handicap, and was rejected under circumstances which gave rise to the inference that his rejection was based solely on his handicap;

2) Once [the] plaintiff establishes his prima facie case, defendants have the burden of going forward and proving that [the] plaintiff was not an otherwise qualified disabled person, that is one who is able to meet all of the program's requirements \textit{in spite} of his handicap, or that his rejection from the program was for reasons other than his handicap;

3) The plaintiff then has the burden of going forward with rebuttal evidence showing that the defendants' reasons for rejecting the plaintiff are based on misconceptions or unfounded factual conclusions, and that reasons articulated for the rejection other than handicap encompass unjustified consideration of the handicap itself.\textsuperscript{129}

c. The availability of damages as a remedy in a section 504 cause of action

When a plaintiff brings a private cause of action for violation of a federal statute, the availability of remedies becomes an important issue. The Eighth Circuit addressed the issue of whether damages were available for a violation of section 504 in\textit{Miener v. Mis-}

\textsuperscript{126}\textit{Id.}
\textsuperscript{127}\textit{Pushkin}, 658 F.2d at 1380.
\textsuperscript{128} 442 U.S. 397 (1979). In this case, the Supreme Court declined to decide whether a private cause of action could be implied under § 504. The Court found that the handicapped person bringing suit did not meet the "otherwise qualified" requirement of the statute. \textit{Id.} at 405-14. Therefore, it was unnecessary to address the issue of whether a private cause of action existed because of the disposition of the case on its merits. \textit{Id.} at 405 n.5.
\textsuperscript{129}\textit{Pushkin}, 658 F.2d at 1387; see also\textit{Davis}, 442 U.S. at 397.
Terri Ann Miener had a history of medical problems that resulted in serious learning disabilities. She brought suit, alleging that she was denied equal access to educational facilities in violation of section 504.

The Miener court identified the principle enunciated by the Supreme Court in *Bell v. Hood* — that where legal rights are invaded and a federal statute provides a right to sue for such invasion, federal courts may use any available remedy to correct the wrong. The court noted that administrative enforcement remedies provided under the Act were inadequate to vindicate individual rights. Support for a damage remedy could be found in the legislative history of the 1978 amendments to the Act. Additionally, the court pointed to the right to seek money damages for civil rights violations as an accepted feature of the American judicial system. Consequently, it held that damages could be awarded under section 504.

Numerous courts have held that a private right of action exists under section 504, and some federal courts have determined that money damages are available for a violation of the statute. However, the issue arises whether a person with a communicable disease qualifies as an "otherwise qualified" handicapped individual, enabling him to exercise that private right of action.

### 3. The Supreme Court's Application of the Rehabilitation Act to Communicable Diseases

The words "handicapped" and "disabled" quickly engender a number of commonly recognized conditions, such as blindness, deafness, and the inability to walk or speak. However, until recently, the...
issue of whether a communicable disease could ever be considered a disability under section 504 was unresolved. This issue was resolved by the United States Supreme Court in School Board v. Arline, where the Court extended the Rehabilitation Act's coverage to include tuberculosis, a contagious disease. The Court addressed whether the language and history of section 504 supported the inclusion of communicable diseases within the scope of the Act's protection. In its analysis, the Court balanced two conflicting interests: the disabled individual's interest in being protected from discrimination, and the general public's competing right to be protected from the spread of communicable diseases.

Gene Arline, the plaintiff in this case, began teaching elementary school in Nassau County, Florida in 1966. She had been hospitalized for tuberculosis in 1957, but remained in remission until a relapse occurred in 1977. After two additional relapses in 1978, she was suspended and eventually dismissed because of the disease's continued recurrence.

The Supreme Court first held that Arline was disabled within the meaning of the Act because her previous hospitalization for tuberculosis meant that she had a record of impairment. The school board argued that the record of impairment was irrelevant and that they had discharged Arline "because of the threat that her relapses of tuberculosis posed to the health of others." The Supreme Court rejected this argument, stating that such a result "would be inconsistent with the basic purpose of § 504, which is to insure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others." The Court then explained that although some persons with contagious diseases may pose a health threat to others, that fact does not justify exclud-

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142. Id. at 277-86.
144. Arline, 480 U.S. at 277-86.
145. Id. at 276.
146. Id.
147. Id.
148. Id. at 281. See supra note 84 and accompanying text for the definition of handicap.
149. Arline, 480 U.S. at 276.
150. Id. at 284.
ing all persons with contagious diseases from the Act's coverage.\textsuperscript{151} The Court concluded that a person's contagious status does not necessarily remove her from coverage under section 504.\textsuperscript{152}

The Court then remanded the case to the lower court to determine whether Arline was "otherwise qualified"\textsuperscript{153} as an elementary teacher.\textsuperscript{154} The Court identified an "otherwise qualified" person as "one who is able to meet all of a program's requirements in spite of his handicap."\textsuperscript{155} The Court delineated four factors that are essential to the "otherwise qualified" inquiry:

\begin{quote}
[T]his inquiry should include "[findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm."\textsuperscript{156}
\end{quote}

In making these findings, the Supreme Court noted that courts should normally defer to the reasonable medical judgments of public health officials.\textsuperscript{157} Once a court evaluates the medical findings, it must then evaluate if the "otherwise qualified" individual could be "reasonably accommodated."\textsuperscript{158}

The Supreme Court reached three conclusions in \textit{Arline}. First, after emphasizing the broad scope of the Act, it held that tuberculosis, a contagious disease, constituted a disability, and that Arline was a "handicapped individual" within the meaning of section 504.\textsuperscript{159} Second, the risk of contagion should be considered in determining whether a "handicapped individual" is "otherwise qualified," rather than viewed as an exception to the Act's coverage.\textsuperscript{160} Third,
in order to determine whether a person who is disabled by a contagious disease is "otherwise qualified," the court must conduct an individualized inquiry based on medical knowledge and scientific fact.\footnote{161}

The *Arline* Court expressly declined to rule on whether the HIV infection might constitute a disability for purposes of section 504.\footnote{162} However, because *Arline* held that at least one contagious disease was protected by the Act, it opened the door to the possibility that other contagious diseases, such as AIDS-related disorders, would be similarly protected.\footnote{163}

4. Application of the Rehabilitation Act to AIDS

The concepts developed in *Arline* were subsequently extended to HIV-positive individuals in *Chalk v. United States District Court Central District of California*,\footnote{164} where the Ninth Circuit recognized AIDS as a communicable disease covered by the Act.\footnote{165} Vincent Chalk was a teacher of hearing-impaired students.\footnote{166} He was hospitalized with pneumocystis carinii pneumonia and was diagnosed with AIDS.\footnote{167} After he returned to work, the Orange County Department of Education placed him on leave and eventually refused to permit his return to normal classroom duties.\footnote{168} Instead, the department offered him an administrative position.\footnote{169} Chalk refused the offer and brought suit, seeking a preliminary and permanent injunction to prevent the department from excluding him from normal classroom duties.\footnote{170} The district court denied the injunction.\footnote{171}

On appeal, the Ninth Circuit applied the Supreme Court's four-
part Arline test and found that there was a substantial probability that Chalk would be found "otherwise qualified." It directed the lower court to issue a preliminary injunction, which allowed Chalk to return to the classroom. The Chalk decision is significant for its recognition of AIDS as a disability under section 504 of the Act. It is also important for its judicial stance in applying the reasoning of Arline to HIV carriers.

Under section 504, courts have held that an HIV-positive person qualifies as a disabled person. However, the Rehabilitation Act only applies to programs and activities "receiving federal financial assistance." Therefore, to bring a successful section 504 action, it is important to establish that discrimination occurred within a federally funded program.

5. Receipt of Medicare or Medicaid Constitutes "Receiving Federal Financial Assistance"

When a plaintiff alleges a violation of section 504 in the health

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172. See supra notes 153-56 and accompanying text (discussing Arline's "otherwise qualified" inquiry).
173. Chalk, 840 F.2d at 708.
174. Id. at 712.
175. See id. at 704-05. In addition to the Ninth Circuit, several other circuit courts have held that AIDS is a handicap as defined by the Act. See Severino v. North Fort Myers Fire Control Dist., 935 F.2d 1179 (11th Cir. 1991) (finding that an HIV-positive fire fighter was handicapped within the meaning of the Rehabilitation Act); Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1, 909 F.2d 820 (5th Cir. 1990) (assuming for purposes of appeal that seropositivity to HIV antibodies is an impairment protected under § 504).
176. Coreen K. Sweeney, Note, AIDS in the Workplace: A Handicap Under the Law?, 39 Drake L. Rev. 141, 149 (1989-1990). The "otherwise qualified" inquiry was applied in a case involving a hospital's alleged discrimination against an HIV-positive health care worker, with the result that the plaintiff was not "otherwise qualified" to perform his job. See Leckelt, 909 F.2d at 827.

Kevin Leckelt was employed at a hospital as a licensed practical nurse. Id. at 821. The hospital became aware that Leckelt was the roommate of a current AIDS patient at the hospital. Id. at 822. After reviewing its infection control policies and investigating guidelines from the Centers for Disease Control and the American Hospital Association, the hospital determined that it needed to know whether the employee was seropositive for HIV antibodies. Id. When Leckelt failed to submit the results of a previously completed HIV test, he was terminated for failure to comply with hospital policy. Id. at 824.

The court held that Leckelt was not discriminated against solely because of a perception that he was infected with HIV. Id. at 825-26. Rather, he was terminated because he had violated the hospital's infection control policies on reporting infectious or communicable diseases. Id. at 826. Additionally, the court determined that Leckelt was not "otherwise qualified" to perform his job as a licensed practical nurse because of his failure to comply with the hospital's infection control policies. Id. at 830.
care context, an important issue is whether a hospital’s receipt of Medicaid and Medicare triggers the coverage of section 504. In *United States v. Baylor University Medical Center*, the Fifth Circuit addressed this issue and determined that section 504 applied. Approaching this as a question of first impression, the appellate court held that receipt of Medicare and Medicaid constituted federal financial assistance.

In this case, the Department of Health and Human Services (HHS) received a complaint that Baylor University Medical Center refused to permit a deaf patient to obtain an interpreter. Apparently, the patient requested the interpreter so that she could understand pre- and post-operative discussions with the staff. After Baylor refused to allow HHS to investigate the complaint, the United States filed suit alleging that Baylor’s refusal violated section 504 and the regulations implementing the statute.

The *Baylor* court grounded its determination that the receipt of Medicare payments triggered section 504 on three congruent sources: the legislative history of the statutes prohibiting discrimination in federally funded programs; judicial interpretation of these statutes; and regulations adopted pursuant to the statutes. In addressing these sources, the court stated that section 504 was explicitly patterned after the discrimination prohibitions of Title VI of the Civil Rights Act of 1964, which prohibit discrimination on the basis of race or national origin in federally funded programs. Additionally, the court noted that when Congress passed Medicare and Medicaid legislation in 1965, several senators stated that the prohibitions of Title VI would apply to recipients of Medicare and Medicaid. The *Baylor* court reasoned that the Rehabilitation Act’s language and legislative history indicate that its prohibition of

179. *Id.* at 1042.
180. *Id.* at 1040. In addition, the Third Circuit affirmed a district court opinion that held in part that Medicare and Medicaid triggered § 504. However, the court did so with no discussion of the issue. Rather, the issue was affirmed in a footnote. *NAACP v. Medical Ctr., Inc.*, 599 F.2d 1247, 1248 n.4 (3d Cir. 1979).
181. *Baylor*, 736 F.2d at 1041. The hospital would not have incurred any added expense by allowing the patient to bring in the interpreter. *Id.*
182. *Id.*
183. *Id.* at 1042.
185. *Baylor*, 736 F.2d at 1042-43.
186. *Id.*
discrimination on the basis of disability was equivalent to Title VI's prohibition of discrimination on the basis of race. Moreover, the legislative history of the Medicare and Medicaid bill showed that Congress intended these forms of federal assistance to trigger federal antidiscrimination protection.

The *Baylor* case makes it clear that the receipt of Medicare and Medicaid payments constitutes federal financial assistance for purposes of the Act. Accordingly, every health care facility or individual health care provider who receives Medicare and Medicaid payments qualifies as a program that is subject to the Act's coverage.

6. *Determining the Scope of Section 504's Coverage When a Program Receives Federal Funds*

An institution may receive federal funding for one or more of its activities or programs, and it may also conduct programs that do not receive federal funding. Therefore, in order to determine who may be subject to section 504's provisions, it is important to identify the extent of the statute's coverage when a particular program within an institution receives federal financial assistance.

The implementation of section 504 closely follows the antidiscrimination provisions of Title VI and Title IX. Since Congress patterned both section 504 and Title IX after Title VI, judicial interpretation of one of these statutes also has ramifications for the others.

187. *Id.* at 1045.

188. *Id.* According to the court, the issue of whether Medicare and Medicaid constituted federal financial assistance to a program or activity was not extensively debated when the legislation was passed in 1965. *Id.* at 1044. However, as the court noted, several senators stated that the prohibitions of Title VI would apply to recipients of Medicare and Medicaid. *Id.* Senator Ribicoff stated that in order to receive federal financial payments, hospitals would have "to abide by Title VI." *Id.* (citing 111 CONG. REC. 15,813). Additionally, Senator Hart commented:

Federal tax funds collected from all the people may not be used to provide benefits to institutions or agencies which discriminate on the grounds of race, color, or national origin. This principle will . . . apply to hospital[s] and extended care and home health services provided under the social security system, and will require institutions and agencies furnishing these services to abide by title [VI] of the Civil Rights Act of 1964.

111 CONG. REC. 15,813 (1965), quoted in *Baylor*, 756 F.2d at 1044 n.13.

189. *See Pushkin v. Regents of the Univ. of Colo.*, 658 F.2d 1372, 1379 (10th Cir. 1981). Title IX prohibits discrimination on the basis of sex in federally funded programs. The "Assurance of Compliance" is essentially a promise to comply with the statute.

The Supreme Court was faced with determining the scope of Title IX in *Grove City College v. Bell.* Grove City College was a private coeducational college that refused state and federal financial assistance in order to retain its autonomy. However, Grove City enrolled a large number of students who received Basic Educational Opportunity Grants (BEOGs) under the Department of Education’s Alternative Disbursement System. Under this system, students received the assistance directly. As a result, the Department determined that Grove City was a recipient of federal financial assistance, as defined in Title IX’s regulations, and they requested that the college execute the Assurance of Compliance required by the statute. When Grove City refused to comply, the Department determined that the college and its students were no longer eligible to receive BEOGs. Grove City and four of its students filed suit to prevent termination of the students’ financial assistance.

The Supreme Court held that because some of its students received BEOGs, Grove City was a recipient of federal financial assistance. Grove City argued that because the students received the assistance personally, the school was not a recipient of federal funding, and therefore was not subject to regulation. The Court rejected the argument. Looking at the language of the statute and its legislative history, the Court determined that Congress did not “perceive a substantive difference between direct institutional assistance and aid received by a school through its students.” The Court noted that quite often the economic effects of direct and indirect assistance are indistinguishable.

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192. Id. at 559.
193. Id.
194. There are two procedures for computing and disbursing BEOGs. Under the Regular Disbursement System, the Secretary of Education estimates the amount that an institution will need for grants and advances that sum to the institution which itself selects eligible students, calculates awards, and distributes the grants. The Alternative Disbursement System is a second option to minimize government involvement in the administration of the BEOG program. Under this option, institutions must make appropriate certifications to the Secretary, but the Secretary calculates the awards and makes disbursements directly to eligible students. Id. at 559 n.5.
196. See *Grove City College,* 465 U.S. at 560. See also 34 C.F.R. § 106.4 (1991).
197. *Grove City College,* 465 U.S. at 561.
198. Id.
199. Id. at 563-64.
200. Id. at 564.
201. Id.
202. Id. at 565.
However, the Court stated that the receipt of BEOGs by some of Grove City’s students did not subject the entire institution to coverage under Title IX. The BEOGs constituted financial assistance to Grove City’s financial aid program, and it was only that program that could be regulated under the program-specific limitations of the statute.

Within a month and a half of this decision, bills to override Grove City College were introduced. A Senate committee report stated that the Grove City College ruling severely narrowed the coverage of the four major civil rights statutes that prohibit discrimination in federally assisted programs: Title IX of the Education Amendments of 1972, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Congress stated, “The purpose of the Civil Rights Restoration Act of 1987 is to reaffirm pre-Grove City College judicial and executive branch interpretations and enforcement practices which provided for broad coverage of the antidiscrimination provisions of these civil rights statutes.” Each of the affected statutes was amended by adding a section defining “program” or “activity” to make it clear that discrimination is prohibited throughout an entire agency or institution if any part receives federal financial assistance.

The United States Supreme Court was presented with another opportunity to interpret the scope of section 504 in United States Department of Transportation v. Paralyzed Veterans of America. The Court held that section 504’s coverage is limited to those who

203. Id. at 573. The Court addressed an additional argument made by the college, that the Department of Education could only regulate the administration of the program. The Court dismissed the assertion, saying that students who participated in the college’s federally assisted financial aid program, but who did not themselves receive financial funds, were also protected against discrimination. Id. at 571 n.21.

204. Id. at 573-74.


207. Id.


actually "receive" federal financial assistance. The Civil Aeronautics Board (CAB) argued that section 504 supported regulatory jurisdiction over only those air carriers which received funds under the Federal Aviation Act of 1958. Certain organizations representing disabled individuals brought an action in the United States Court of Appeals for the District of Columbia, challenging the CAB's interpretation of its rulemaking authority under section 504. The Court of Appeals held that section 504 gave the CAB jurisdiction over all air carriers by virtue of the federal financial assistance provided to airports under the Airport and Airway Development Act.

On certiorari, the United States Supreme Court reversed and remanded the case. It found that commercial airlines were not recipients of federal financial assistance and therefore section 504 was inapplicable to commercial airlines.

The Court looked at the language of section 504 and found that by its terms, its coverage is limited to the "program or activity" that "receiv[es] Federal financial assistance." To identify the recipient of the federal assistance, the Court looked at the underlying grant statutes and found that Congress intended that the airport operators receive these funds. According to the Court, Congress sought to impose section 504 coverage as an obligation tied to the recipient's agreement to accept the federal funds. The Court stated, "by limiting coverage to recipients, Congress imposes the obligations of § 504 upon those who are in a position to accept or reject those obligations as part of the decision whether or not to 'receive' federal funds."

210. Id. at 605.
211. Id. at 600. See 49 U.S.C. app. §§ 1376(b), 1389 (1982) (authorizing the CAB to fix reasonable rates of federal compensation for air carriers that transport mail, and to determine whether federal compensation is necessary in order to ensure basic, essential air service to a given area).
212. Paralyzed Veterans of Am., 477 U.S. at 599.
213. Id. at 603. The United States provides financial assistance to airport operators through a trust fund created by the Airport and Airway Development Act of 1970 and its successor statute, the Airport and Airway Improvement Act of 1982. 49 U.S.C. app. §§ 2201-2227 (1982).
214. Paralyzed Veterans of Am., 477 U.S. at 603-12.
215. Id. at 604.
217. Paralyzed Veterans of Am., 477 U.S. at 605.
218. Id.
219. Id. at 606.
The Court rejected the argument that the airlines were “indirect recipients” of the aid to airports.\footnote{220} It distinguished intended beneficiaries from intended recipients.\footnote{221} Although it stated in Grove City College that there was no distinction between direct and indirect aid,\footnote{222} the Court decided that these statements were made with regard to Congress’s intended recipient.\footnote{223} While Grove City College stood for the proposition that Title IX coverage extends to Congress’s intended recipient, whether the aid was received directly or indirectly, it did not mean that coverage attached to those who merely benefitted from the aid.\footnote{224} In this case, the airlines did not receive the aid, but simply benefitted from the airports’ use of the aid.\footnote{225} The Court noted that if section 504’s scope was tied to economic benefit, it would result in almost limitless coverage.\footnote{226}

Justice Marshall dissented, joined by Justices Brennan and Blackmun. He stated that the appropriate question was not whether commercial airlines received federal financial assistance.\footnote{227} Rather, citing the language of section 504, he reasoned that the appropriate question should be whether such airlines were in a position to exclude handicapped persons from the participation in, to deny them the benefit of, or to subject them to discrimination under a program or activity receiving federal financial assistance.\footnote{228} The dissenters believed that the Airport and Airway Improvement Act of 1982 should be viewed as creating “programs” or “activities” related to the construction and maintenance of safe and efficient airports and airways.\footnote{229}

Marshall then stated that the next question was whether the Department of Transportation (DOT) had jurisdiction over commercial
airlines under section 504 for the purpose of ensuring that handicapped individuals were not "excluded from the participation in, . . . denied the benefits of, or . . . subjected to discrimination under" those programs or activities.\textsuperscript{230} In the dissent's view, the nature of airline transportation made it essential that DOT have such authority, since commercial airlines were "in a unique position to deny public access to federally funded airport and airway services."\textsuperscript{231}

Within a year after \textit{Paralyzed Veterans} was decided, Congress responded with the Air Carrier Access Act of 1986.\textsuperscript{232} This Act specifically prohibited air carriers from discriminating against "otherwise qualified handicapped individual[s]" in the provision of air transportation.\textsuperscript{233} Although the Act did not affect section 504 directly, it reflected congressional disapproval of the Supreme Court's interpretation of section 504 in \textit{Paralyzed Veterans}.\textsuperscript{234}

\textit{Grove City College, Paralyzed Veterans}, and the legislation passed as a result of these decisions highlight the difference between the Supreme Court's and Congress's interpretations of the scope of antidiscrimination statutes, including section 504. Each time the Supreme Court attempted to narrow the coverage of the provisions, Congress responded with legislation broadening that coverage.

\textbf{E. The Doctrine of Respondeat Superior}

In the context of bringing a cause of action under section 504, courts have considered the question of whether vicarious liability can be applied under the doctrine of respondeat superior. In other words, an issue may arise whether employers can be held liable for the section 504 violations of their employees. Before applying vicarious liability to section 504 actions, it is important to understand the basic doctrine itself.

\textsuperscript{230} \textit{Id.}

\textsuperscript{231} \textit{Id.} at 615-16.


\textsuperscript{234} Eskridge, \textit{supra} note 205, at 631.
1. Respondeat Superior Generally

"Respondeat superior" is a Latin phrase meaning "let the master answer." Under the common law principle of respondeat superior, an employer is liable for the torts committed by his employee in the furtherance of the employer's business, regardless of the employer's fault. The policy behind respondeat superior is to encourage employers and other principals to monitor their employees' conduct. Behind this policy is the belief that employers and other principals can often prevent their employees or agents from committing torts in the furtherance of the employer's business.

There is an important distinction between employees or servants on the one hand, and independent contractors on the other. The Restatement (Second) of Agency defines a "master" as a principal who employs an agent, and who controls or has the right to control the physical conduct of the agent in the performance of a service. A "servant" is an agent employed by a master, whose physical conduct is controlled or subject to the control of the master. By contrast, an independent contractor is a person who contracts with another to do something for him, but who is not controlled by the other or subject to the other's control with respect to his physical conduct. Generally, an employer is not liable for the torts of an independent contractor. Therefore, in determining whether the doctrine of respondeat superior applies, it is important to identify the actor either

236. Rosenthal & Co. v. Commodity Futures Trading Comm'n., 802 F.2d 963, 966 (7th Cir. 1986). The Restatement (Second) of Agency states that "[a] master is subject to liability for the torts of his servants committed while acting in the scope of their employment." Restatement (Second) of Agency § 219 (1958). An employee's conduct is within the scope of employment if it is of the kind he was employed to perform, it occurs substantially within authorized space and time limits, and it is actuated, at least in part, by the purpose of serving the master. Id. § 228. Unauthorized acts may fall within the scope of employment. Id. § 230.
238. Id. at 969.
239. Restatement (Second) of Agency, supra note 236, § 2.
240. Id.
241. Id. An independent contractor is one who, in the exercise of independent employment, contracts to do a piece of work according to his own methods and is subject to his employer's control only as to the end product or final result of his work. Hammes v. Suk, 190 N.W.2d 478, 480-81 (Minn. 1971).
as a "servant" or an "independent contractor." Although no single factor is determinative as to the existence of a master-servant or employer-independent contractor relationship, the right of an employer to control the employee in his performance of assigned tasks indicates a master-servant relationship. The more extensive this control, the more likely it is a court will hold that such a relationship exists.

2. The Effect of an Employee's Nonliability upon Vicarious Liability of an Employer

In a case where the employer's liability depends solely upon the doctrine of respondeat superior, a plaintiff cannot recover against the employer for damages resulting from the alleged wrongful or negligent act of his employee after the employee has been dis-

243. In determining whether one acting for another is a servant or an independent contractor, the Restatement (Second) of Agency lists factors which may be considered:
(a) the extent of control which, by the agreement the master may exercise over the details of the work;
(b) whether or not the one employed is engaged in a distinct occupation or business;
(c) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer, or by a specialist without supervision;
(d) the skill required in the particular occupation;
(e) whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work;
(f) the length of time for which the person is employed;
(g) the method of payment, whether by the time or by the job;
(h) whether or not the work is a part of the regular business of the employer;
(i) whether or not the parties believe they are creating the relation of master and servant; and

(j) whether the principal is or is not in business.

RESTATEMENT (SECOND) OF AGENCY, supra note 236, § 220.

244. Newcomb v. North East Ins. Co., 721 F.2d 1016 (5th Cir. 1983). See also In re Falkiner, 716 F. Supp. 895, 902 (E.D. Va. 1988) (delineating the elements considered in determining whether an employment relationship exists as: the engagement of the employee, whether wages are paid, the employer's power to dismiss and to control the alleged employee, and deeming the power to control, including the manner in which work is done, the most important); Longo v. Pennsylvania Elec., 618 F. Supp. 87, 90 (W.D. Pa. 1985) ("The hallmark of a master-servant relationship is that the master not only controls the result of the work but has the right to direct the manner in which the work shall be accomplished; the hallmark of an independent [contractor] is that the person engaged in the work has exclusive control of the manner of performing it . . . .") aff'd, 856 F.2d 183 (3d Cir. 1988); Afonso v. City of Boston, 587 F. Supp. 1342 (D. Mass. 1984) (stating that the critical test of a master-servant relationship is the existence of the master's right to control the servant's actions); Beach v. Owens-Corning Fiberglass Corp., 542 F. Supp. 1328 (N.D. Ind. 1982) (stating that the real and decisive test for the existence of a master-servant relationship is the right to command the act and to direct and control the means, manner, or method of performance), aff'd, 728 F.2d 407 (7th Cir.), cert. denied, 469 U.S. 825 (1984).

245. Newcomb, 721 F.2d at 1017.
charged from personal liability. When recovery is sought against an employer and an employee on the basis of the employee's wrongful act, a verdict exonerating the employee also exonerates the employer. Therefore, a verdict releasing the employee from liability, while holding the employer liable under the doctrine of respondeat superior, must be set aside.

3. Vicarious Liability as Applied to Hospitals

There are many cases applying or recognizing the view that a hospital, as an employer, master, or principal, may be held liable for the negligence of a physician under the doctrine of respondeat superior.

246. 53 Am. Jur. 2d Master and Servant § 406 (1970). See also Smith v. Globe Ford, Inc., 467 A.2d 1262, 1267 (Conn. Super. Ct. 1983); Kirk v. Michael Reese Hosp. & Medical Ctr., 513 N.E.2d 387 (Ill. 1987) (holding that when suit is brought against the master based solely on the servant's negligent acts, if the servant is found not guilty, it necessarily follows that the master cannot be guilty), cert. denied, 485 U.S. 905 (1988); Moran v. North County Neurosurgery, 714 S.W.2d 231 (Mo. Ct. App. 1986) (establishing that where a plaintiff's right to recover against a master is dependent entirely on respondeat superior and there is a finding of no negligence by the servant, there should be no judgment against the master); Skalos v. Higgins, 449 A.2d 601 (Pa. Super. Ct. 1982) (stating that where master and servant are joined in an action wholly based on the servant's negligence, the master cannot be held liable unless there is a cause of action against the servant); Morton v. Chesapeake & Ohio Ry., 399 S.E.2d 464 (W.Va. 1990) (concluding that where master and servant are sued jointly in an action based solely on the tortious conduct of the servant, if the servant is acquitted of guilt, there can be no recovery against the master).

247. Bausback v. K Mart Corp., 550 N.E.2d 1269 (Ill. App. Ct. 1990); Williams v. Venture Stores, 673 S.W.2d 480 (Mo. Ct. App. 1984). See also Sanders v. Roberts, 563 So. 2d 1022, 1024 (Ala. 1990) (applying the rule that if the servant's conduct is the only basis of liability against the master, then a verdict exonerating the servant normally relieves the master of liability); Louisville & Nashville R.R. v. Garrett, 378 So. 2d 668, 676 (Ala. 1979) (delineating the general rule that a verdict exonerating a servant generally relieves the master of liability when the servant's conduct is the only basis of liability against the master); Roughton Pontiac Corp. v. Alston, 372 S.E.2d 147 (Va. 1988) (holding that the principle that a verdict for a servant necessarily exonerates the master where the master's liability is solely dependent on the servant's conduct applies to intentional tort cases as well as to negligence cases).

248. 53 Am. Jur. 2d Master and Servant § 406 (1970). See also Colonial Stores v. Fishel, 288 S.E.2d 21 (Ga. Ct. App. 1981) (stating that when a lawsuit is brought against a servant and master based on the doctrine of respondeat superior, the verdict against the master may be set aside where the verdict releases the servant and where the pleadings and evidence fail to show any independent tort of the master); Moran, 714 S.W.2d at 231 (explaining that when verdicts are entered which inconsistently exonerate the servant of negligence yet hold the master liable, the proper remedy is to grant the employer a judgment notwithstanding the verdict); Williams, 673 S.W.2d at 483 (finding that the verdict in favor of employees warranted the trial court's entry of judgment for the employer notwithstanding the verdict, where employer's liability was predicated solely on employees' wrongful act); White v. Lovgren, 387 N.W.2d 483 (Neb. 1986) (stating that where there is no evidence that the master has been negligent other than through imputation of the servant's negligent conduct under respondeat superior, judgment in favor of the servant on the merits renders invalid any judgment against master).
In such a situation, a hospital's liability is limited to conduct that is within the scope of the physician's employment or that is performed at the direction of the hospital. As a general rule, a hospital is not liable for the negligence of a physician functioning as an independent contractor. Therefore, a recurring issue has been whether a particular physician, charged with malpractice, is a servant/agent of a hospital or rather, is an independent contractor. The courts have treated the issue as a factual matter to be determined by assessing all the factors in a particular case. Several factors or relationships may reveal the status of a physician. For example, a resident physician is a servant of the hospital because of the nature of his duties and obligations to the hospital. Some factors which indicate a master-servant relationship include the hospital's payment of wages or fees, its provision of equipment, supplies, support personnel, or office space.

249. In the following states, the courts have held or recognized that a hospital may be held liable for the negligence of a physician who is the agent, servant, or employee of the hospital under the general rule that an employer or principal may be held liable for the tortious conduct of an agent, servant, or employee: Alaska, Arizona, Arkansas, California, Delaware, District of Columbia, Florida, Georgia, Illinois, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Washington, West Virginia, and Wisconsin. John D. Hodson, Annotation, Liability of Hospital or Sanitarium for Negligence of Physician or Surgeon, 51 A.L.R. 4TH 235, 260 (1987 & Supp. 1991).

The general principles of respondeat superior were not always applied to hospitals. The first case to change this was Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957), where the New York Court of Appeals ruled that a hospital’s liability for the negligence of its employees must be governed by the same principles that apply to all other employers. Id. at 9. Historically, charitable hospitals were not held responsible for the negligence of their physicians and nurses. Id. at 5-6. Over time, a body of law developed making the liability of a hospital for the acts of its employees depend on whether the injury-producing act was “administrative” or “medical.” Id. at 3. However, no clear distinction between the two terms existed, so courts were inconsistent in applying the terms. Id. The court’s decision in Bing changed the parameters of a hospital’s liability for the acts of its employees.

250. Reynolds v. Swigert, 697 P.2d 504, 508 (N.M. Ct. App. 1984) (explaining that if a physician is an employee of a hospital, the hospital may be held liable for tortious acts done by the physician within the scope of his employment).

251. Elam v. College Park Hosp., 183 Cal. Rptr. 156, 159 (Cal. Ct. App. 1982) (citing precedent that a hospital may not be liable for a doctor’s malpractice absent a relationship where the doctor is actually employed by the hospital or is ostensibly the agent of the hospital).

252. Hodson, supra note 249, at 245.

253. Id.

254. Id.

255. Kelley v. Rossi, 481 N.E.2d 1340, 1343 (Mass. 1985) (stating that in a medical malpractice action brought against a resident physician and a hospital, a house officer, such as a resident, has certain obligations that demonstrate he is a servant of the hospital).
and its practice of billing patients for the services provided by the physician.\textsuperscript{256} The courts generally view such support as evidence that the physician is an employee of the hospital or that the hospital has control over the physician.\textsuperscript{257} Additionally, where the hospital sets the physician’s schedule and establishes policies and procedures to be followed by the physician, courts have considered this a regulation of the physician’s work.\textsuperscript{258} The hospital’s control supports the conclusion that it has made the physician its agent.\textsuperscript{259}

The doctrine of apparent or ostensible agency provides an exception to the general rule that a hospital is not liable for the negligence of a physician with independent contractor status.\textsuperscript{260} Courts

\textsuperscript{256} Hodson, \textit{supra} note 249, at 247. \textit{See also} Gregg v. National Medical Health Care Servs., 699 P.2d 925, 929 (Ariz. Ct. App. 1985) (holding that the fact that a physician was paid a weekly sum to commute to the hospital to act as a consultant raised a question of fact whether the physician was a part-time employee rather than an independent contractor); Hodges v. Doctors Hosp., 234 S.E.2d 116, 118 (Ga. Ct. App. 1977) (stating that where a hospital paid a doctor for providing emergency room services, required him to provide those services to remain on staff, and exercised control over him, such evidence raised a question whether the physician was an employee); Hill v. St. Clare’s Hosp., 490 N.E.2d 823, 828-29 (N.Y. 1986) (holding that the owner of a medical clinic could be vicariously liable for a physician’s negligence where the bill for services bore the name of the clinic and the owner, payment was made to the owner, and the owner wrote weekly checks to physicians); Mertsaris v. 73rd Corp., 482 N.Y.S.2d 792, 801 (N.Y. App. Div. 1984) (asserting that because an anesthesiologist had an office and sleeping quarters at the hospital, and the hospital billed patients for his services, these facts supported the finding that the hospital was vicariously liable); Thomas v. Raleigh Gen. Hosp., 358 S.E.2d 222, 225 (W. Va. 1987) (holding that a hospital could be vicariously liable for a physician’s negligence where it gave an anesthesiologist an office and stipend for his duties, and the patient had no choice in choosing an anesthesiologist).

\textsuperscript{257} Hodson, \textit{supra} note 249, at 247.

\textsuperscript{258} \textit{Id.} at 248. \textit{See also} Beeck v. Tucson Gen. Hosp., 500 P.2d 1153 (Ariz. Ct. App. 1972) (pointing out that the fact that a hospital had the right to control performance standards of a radiologist supported the hospital’s liability); Suhor v. Medina, 421 So. 2d 271 (La. Ct. App. 1982) (indicating that two factors considered in determining the hospital’s liability were that the physician was required to be “on duty” to perform emergency services, and that the hospital had control over working time and physical activities); Willoughby v. Wilkins, 310 S.E.2d 90 (N.C. Ct. App. 1983) (finding that the employer-employee relationship was supported by evidence that the employment contract specified the physician’s leave and vacation time, the physician’s work schedule was subject to the hospital’s approval, and the physician could not maintain a private practice); Smith v. St. Francis Hosp., 676 P.2d 279, 281 (Okla. Ct. App. 1983) (holding that an emergency room physician, employed by a corporation which staffed the hospital’s emergency room, was an agent of the hospital where he was required to comply with hospital regulations, was reviewed by the hospital, and was required to meet hospital quality of care standards).

\textsuperscript{259} Hodson, \textit{supra} note 249, at 248. \textit{See also} Newton County Hosp. v. Nickolson, 207 S.E.2d 659, 662 (Ga. Ct. App. 1974) (describing the true test of whether a person is employed as a servant or independent contractor as whether the employer has the right to direct the time, manner, methods, and means of execution of the work); Reynolds v. Swigert, 697 P.2d 504 (N.M. Ct. App. 1984) (considering the fact that the hospital retained the right to exercise control over all details of the physician’s professional work through the physician’s employment contract).

\textsuperscript{260} The labels “ostensible agency,” “apparent authority,” and “agency by estoppel” appear to
have held that ostensible agency occurs where a hospital "holds out" to its patients that it is a provider of medical services, the patient goes to that hospital, and the patient relies on the hospital to deliver those medical services.\textsuperscript{261} Ostensible agency also applies where the hospital "holds out" to patients that the physicians associated with it are its employees.\textsuperscript{262} Some courts have concluded that ostensible agency exists under either of the two "holding out" theories where the physician was not independently selected by the injured patient, but instead was selected by the hospital as the treating physician upon which the patient relied for medical care.\textsuperscript{263}

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\textsuperscript{261} Hardy v. Brantley, 471 So. 2d 358, 371 (Miss. 1985) (emphasizing that where a patient engaged and relied on the services of a hospital, and where the hospital held itself out as providing a specific medical service and entered into a contract with physicians to provide the service, the hospital was subject to vicarious liability).

\textsuperscript{262} See Irving v. Doctors Hosp., 415 So. 2d 55, 58 (Fla. Dist. Ct. App.) (superseded by statute on other grounds as stated in In Ginsing v. LaBella, 543 So. 2d 209 (Fla. 1989)) (outlining the doctrines of apparent authority and estoppel; a hospital would be estopped to deny that the physician was its agent if it held itself out to the public as the employer of the physician and caused a third person to rely upon the physician's care).

In the following states, the courts have recognized that a hospital may be liable for the negligence of a physician with independent contractor status where the hospital "holds out" to its patients or the public that it is a provider of medical services, or that the physicians associated with it are its employees: Alaska, Arizona, California, Delaware, Florida, Georgia, Illinois, Kentucky, Maryland, Michigan, Mississippi, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Washington, and Wyoming. Hodson, supra note 249, at 271-73.

\textsuperscript{263} Hodson, supra note 249, at 247. See also Beeck v. Tucson Gen. Hosp., 500 P.2d 1153, 1157-59 (Ariz. Ct. App. 1972) (holding that a hospital was vicariously liable for the malpractice of a radiologist because the hospital chose the radiologist, and patients today expect to be cured by hospitals); Irving, 415 So. 2d at 59 (holding a hospital liable for a doctor's negligence where the jury found that the plaintiff took her daughter to the hospital for hospital treatment); Newton County Hosp., 207 S.E.2d at 662 (stating that when a person is taken directly to a hospital and is diagnosed or treated by a physician hired by the hospital, the doctor is the hospital's servant); Paintsville Hosp. v. Rose, 683 S.W.2d 255, 258 (Ky. 1985) (asserting that a crucial question was whether the plaintiff, upon being admitted to the hospital, was looking to it for treatment, rather than viewing the hospital as a situs where the patient's physician would treat him); Wells v. Woman's Hosp. Found., 286 So. 2d 439, 444 (La. Ct. App. 1973) (concluding that respondeat superior was applicable because the plaintiff did not consult a private physician, but instead was treated by physicians who were "staff-employees" of the hospital); Grewe v. Mount Clemens Gen. Hosp., 273 N.W.2d 429, 433 (Mich. 1978) (finding that a relevant factor in determining whether the patient looked to the hospital for treatment was whether the physician was provided by the hospital or whether the physician and patient had a relationship independent of the hospital setting); Hardy, 471 So. 2d at 371 (concluding that respondeat superior applies where a patient relies on a hospital to provide medical services without regard to the identity of a particular physician); Hill v. St. Clare's Hosp., 490 N.E.2d 823 (N.Y. 1986) (finding the owner of a medical clinic vicariously liable where the patient's prior relationship was with the clinic, rather than with any of the physicians and where the patient accepted physician's services based on the fact that they were offered by the clinic); Capan v. Divine Providence Hosp., 430 A.2d 647, 649 (Pa.
The doctrine of ostensible agency was examined and applied to an independent contractor physician's negligent act in *Grewe v. Mount Clemens General Hospital*.264 There, a patient suffering a dislocated shoulder went to the hospital where several attempts were made to reduce the dislocation.265 After the efforts proved unsuccessful, a physician who was not an employee but who had staff privileges attempted reduction by placing his foot on the patient's chest and pulling the patient's arm.266 The patient later brought suit claiming that these attempts at reduction resulted in nerve damage and a fracture.267

The court acknowledged that, generally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and who merely used the hospital's facilities to render treatment to his patients.268 However, if the individual looked to the hospital to provide him with medical treatment, and there had been a representation by the hospital that medical treatment would be given by the physicians working there, then agency by estoppel could be found.269 The court stated that the critical question was whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment or whether he merely viewed the hospital as the site where his physician would treat him.270 A relevant factor in answering this question was whether the hospital provided the plaintiff with the physician, or whether the plaintiff and the physician had a relationship independent of the hospital setting.271

The *Grewe* court stated that before there could be a recovery against a principal for the alleged acts of an ostensible agent, three things must be proved:

[First,] [t]he person dealing with the agent must do so with belief in the

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Super. Ct. 1980) (explaining that even a physician with independent contractor status may be an ostensible agent of a hospital where patients look to the hospital rather than to the individual physician for care); Edmonds v. Chamberlain Memorial Hosp., 629 S.W.2d 28, 31-32 (Tenn. Ct. App. 1981) (denying summary judgment in favor of the hospital, after considering the fact that the patient relied on the hospital to select a physician).

265. *Id.* at 431.
266. *Id.*
267. *Id.*
268. *Id.* at 432-33.
269. *Id.* at 433.
270. *Id.*
271. *Id.*
agent's authority and this belief must be a reasonable one; [second,] such belief must be generated by some act or neglect of the principal sought to be charged; [finally,] the third person relying on the agent's apparent authority must not be guilty of negligence.  

Applying these principles to the facts of the case, the court found that there was nothing that should have put the plaintiff on notice that the physician in question was an independent contractor. Additionally, the court was convinced that the plaintiff, when he entered the hospital, was seeking treatment from the hospital itself. Since the plaintiff looked to the hospital for his treatment, and was treated by a physician who was an ostensible agent of the hospital, the hospital could be vicariously liable.  

In summary, courts have dealt with the issue of whether a hospital may be held liable for the actions of a physician by assessing various factors to determine whether a master-servant relationship exists. Factors indicating that the hospital had control over the physician will support the application of the doctrine of respondeat superior. However, even if the relationship indicates that the physician had independent contractor status, vicarious liability may still be imputed under the theory of ostensible agency. The issue thus becomes whether vicarious liability may appropriately be applied in a section 504 suit, where a physician has discriminated against an HIV-positive individual.  

4. Respondeat Superior Applied to Actions Brought under Section 504  

In determining whether a hospital may be liable for the actions of a physician who violates section 504, the first issue is whether the doctrine of respondeat superior applies to actions brought under the Act. In *Patton v. Dumpson*, a New York federal district court considered whether vicarious liability was appropriate in an action brought under section 504 and determined that it was. There, William Patton was a disabled child, abandoned by his mother, who became the legal responsibility of certain public and private child

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272. Id. at 434 (quoting Stanhope v. Los Angeles College of Chiropractic, 128 P.2d 705, 708 (Cal. Ct. App. 1942)).
273. Id.
274. Id. at 434-35.
275. Id. at 435.
277. Id. at 942-44.
welfare agencies. William sued the executive heads of the agencies on several grounds, including a claim that they denied him an education solely because he suffered from physical and mental disabilities, in violation of section 504.

The court reasoned that respondeat superior was applicable to section 504 suits and was entirely consistent with the statute's policy of eliminating discrimination against the disabled. In support of this, the court stated:

The justification for imposing vicarious liability on employers for the acts of their employees is well-known. It creates an incentive for the employer to exercise special care in the selection, instruction and supervision of his employees, . . . [i]n the absence of Congressional directive to the contrary, this court can assume only that Congress intended the judiciary to use every available tool to eliminate discrimination against the handicapped in federally funded programs.

The court noted that respondeat superior was also applicable in private actions brought under various other civil rights statutes, such as Title VIII of the Fair Housing Act of 1968 and Title VII of the Civil Rights Act of 1964. The court's analysis identified strong legal precedents and compelling policy considerations that supported the application of respondeat superior to section 504 actions. Therefore, a section 504 plaintiff is not precluded from applying the doctrine in an appropriate situation. However, when such

278. Id. at 935.
279. Id. at 935-36.
280. Id. at 943.
281. Id. In Bonner v. Lewis, 857 F.2d 559 (9th Cir. 1988), the Ninth Circuit addressed an action brought by a deaf inmate against a state correctional facility, alleging deprivation of his rights under § 504. Id. at 561. He also brought a claim against the Director of the Arizona Department of Corrections, based on vicarious liability. Id. at 567.
Bonner was deaf, mute, and suffering from vision loss. Id. at 560. None of the personnel at the state prison where he was an inmate knew sign language. Id. Bonner claimed that his inability to effectively communicate without a qualified interpreter severely inhibited his ability to participate or benefit from various prison programs, hearings, and activities. Id. He alleged that his repeated requests for a qualified interpreter were ignored by prison officials. Id. at 560-61.
Although existing genuine issues of fact precluded summary judgment, the court held that the plaintiff's claim, based on respondeat superior, was appropriate and should not be dismissed. Id. at 563-67. It cited Patton's policy argument as support for the application of vicarious liability to § 504 claims. Id. at 566-67.
a plaintiff brings suit against a physician alleging a violation of section 504 and against a hospital alleging vicarious liability for the acts of the physician, the fact finder must examine the relationship between the physician and the hospital. Furthermore, while vicarious liability may be based on respondeat superior or ostensible agency, *Patton* did not expressly decide the applicability of ostensible agency to a section 504 suit. Therefore, it is uncertain whether courts would find ostensible agency applicable by analogy to respondeat superior. Agency principals are especially important within the context of a hospital’s liability for its physicians’ refusal to treat HIV-infected patients.

5. Determining Liability When a Physician Discriminates on the Basis of HIV-Positive Status

In response to the AIDS epidemic, some health care workers have refused to care for HIV-positive individuals out of fear that they will contract the disease. This creates the potential for a situation in which an HIV-positive individual alleges that a physician’s refusal to continue treatment was a violation of section 504. In this context, the issue arises whether the physician’s hospital could be held vicariously liable. A Massachusetts federal court addressed this exact issue in *Glanz v. Vernick*. There the court held that a hospital could be held vicariously liable for an employee physician’s alleged section 504 violation against an HIV-positive individual. The plaintiff, Vadnais, went to the Ear, Nose and Throat Clinic at Beth Israel Hospital and was referred to Dr. Vernick, a staff physician. Dr. Vernick treated Vadnais for severe ear pain by prescribing antibiotics; one month later he diagnosed a perforation in Vadnais’s right ear. After several visits, Dr. Vernick recommended that surgery be performed to repair the perforation. After Vadnais agreed to the surgery, Vernick learned that Vadnais was infected with HIV. In March of 1987, he informed Vadnais that he would not perform the operation. Vadnais continued to use ear drops and antibiotics, but the painful condition persisted. Nearly one and a

286. *Id.* at 637.
287. *Id.* at 634.
288. *Id.*
289. *Id.*
290. *Id.*
291. *Id.*
half years later, another physician, who was unaware of Vadnais's HIV status, performed the surgery and cured the problem. Vadnais sued Dr. Vernick and Beth Israel Hospital under section 504. He sought to enjoin the defendants from denying him any further surgical procedures and to recover monetary damages.

The first issue that the court addressed was whether Beth Israel qualified as a federally funded program for purposes of the Rehabilitation Act by virtue of its receipt of Medicare and Medicaid payments. The court cited *United States v. Baylor University Medical Center* for the proposition that the receipt of Medicare and Medicaid payments by a hospital triggered the coverage of section 504. Following the decision in *Baylor*, the court in *Grewe v. Mount Clemens General Hospital* held that a hospital's receipt of Medicare and Medicaid payments constituted federal financial assistance for purposes of section 504. Since Vadnais presented himself to the clinic, which in turn referred him to Dr. Vernick, a staff physician, the court refused to grant summary judgment to the defendants on the ground that the alleged discrimination did not occur in a federally funded program. The defendants also asserted that the discrimination did not occur in a federally funded program because Vadnais's surgery was elective and not covered by Medicaid. The court rejected this argument, citing *Grove City College* for the proposition that if the clinic was "a program or activity for the purposes of § 504, then it cannot discriminate against any handicapped individuals, regardless of whether they receive Medicaid benefits or not."

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292. *Id.*
293. *Id.* Vadnais brought suit in April of 1989. Prior to Vadnais's death, the defendants filed motions for summary judgment. After Vadnais's death, the executor of his estate was substituted as plaintiff. The defendants' motion was stayed to allow them to file a motion to dismiss on the ground that the federal cause of action abated with Vadnais's death. In November of 1990, the district court addressed the issue. The court held that statutory construction of federal civil rights statutes was governed by 42 U.S.C. § 1988 which, in turn, governed the choice of law on the question of abatement. Section 1988 provides that when civil rights statutes are "deficient in the provisions necessary to furnish suitable remedies," the federal courts should consult the law of the state. Under Massachusetts' survival statute, the plaintiff's action for compensatory damages survived, but the claim for punitive damages did not. *Glanz*, 756 F. Supp. at 639.
297. *Id.* at 636.
298. *Id.*
299. *Id.*
300. *Id.*
Beth Israel then argued that under Massachusetts case law, a hospital cannot be held liable for the actions of its physicians.301 The court rejected this proposition, saying that the question of liability was properly decided under the principles of agency law.302 The test that the court used for vicarious liability was whether the hospital exercised any power or control over the professional conduct of the physician.303 Applying this test, the court found sufficient evidence that the hospital did exert control over its physicians regarding treatment of HIV-positive patients.304 The hospital’s “AIDS coordinator” contacted Dr. Vernick to ascertain whether his refusal to treat Vadnais was appropriate.305 Other factors the court looked to included the facts that Dr. Vernick received a salary for resident teaching and that the hospital performed the billing for his services.306 These factors supported a finding that Dr. Vernick was the hospital’s employee, rather than an independent contractor.307 Consequently, the court determined that enough factual evidence existed to preclude summary judgment on the ground that the hospital was not liable for Dr. Vernick’s actions.308

Beth Israel’s potential liability depended largely upon the application of vicarious liability to the section 504 cause of action. The court addressed this issue and found the doctrine applicable.309 It cited Bonner v. Lewis310 and Patton v. Dumpson,311 quoting Patton’s policy reasons for permitting vicarious liability in suits brought under section 504.312 In view of these policy reasons, the Glanz court stated, “[I]t is appropriate to hold Beth Israel responsible for

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301. Id.
302. Id.
303. Id. See also Kelley v. Rossi, 481 N.E.2d 1340 (Mass. 1985) (holding that in a medical malpractice action brought against a resident physician and a hospital, the right to control an agent’s activities is the guiding principle in deciding vicarious liability); Kapp v. Ballantine, 402 N.E.2d 463 (Mass. 1980) (holding that in a medical malpractice action brought against physicians and a hospital, the hospital was not vicariously liable because the plaintiff failed to show power or control over the physician’s professional conduct).
305. Id.
306. Id.
307. Id.
308. Id.
309. Id.
310. 857 F.2d 559 (9th Cir. 1988). See supra note 281 for a discussion of Bonner.
the actions of its medical staff in complying with the Rehabilitation Act, even without a finding of power or control."\textsuperscript{313}

The court then addressed whether Dr. Vernick could be held personally liable for discriminating against Vadnais.\textsuperscript{314} Vadnais argued that the doctor should be held liable because he treated Medicare and Medicaid patients in the context of his personal medical practice, and occasionally treated them at the hospital.\textsuperscript{315}

The court began its analysis by citing Grove City College for the proposition that, for programs receiving federal funding, application of antidiscrimination provisions must be program specific.\textsuperscript{316} Therefore, it reasoned that application of section 504 in this case must be "limited to the relevant program receiving federal funds."\textsuperscript{317} The court then identified two distinct programs that Dr. Vernick participated in: 1) his private medical practice from which he personally received Medicare or Medicaid payments, and 2) Beth Israel's clinic at which he held a resident teaching position.\textsuperscript{318} The court identified the second program, Beth Israel's clinic, as the relevant program in this situation.\textsuperscript{319} Therefore, Dr. Vernick's personal liability depended solely on his participation in Beth Israel's program.\textsuperscript{320}

In addressing this issue, the Glanz court cited United States Department of Transportation v. Paralyzed Veterans of America,\textsuperscript{321} which held that section 504's prohibitions apply only to those who actually receive federal funding, but not to those who are merely beneficiaries of the assistance.\textsuperscript{322} Citing the Supreme Court, the court stated that "[b]y limiting coverage to recipients, Congress im-

\textsuperscript{313} Glanz, 756 F. Supp. at 637.
\textsuperscript{314} Id.
\textsuperscript{315} Id.
\textsuperscript{317} Glanz, 756 F. Supp. at 639.
\textsuperscript{318} Id.
\textsuperscript{319} Id.
\textsuperscript{320} Id.
\textsuperscript{321} 477 U.S. 597 (1986).
\textsuperscript{322} Id.
poses the obligations of § 504 upon those who are in a position to accept or reject those obligations as part of the decision whether or not to 'receive' federal funds.\textsuperscript{323} Applying this standard, the \textit{Glanz} court found that Dr. Vernick was not in a position to accept or reject federal assistance in his resident teaching position at Beth Israel.\textsuperscript{324} Moreover, he was not bound by section 504's prohibitions by simply choosing to work at a federally funded hospital.\textsuperscript{325} As a result, the court held that Dr. Vernick could not be held personally liable under the Act for participating in Beth Israel's federally funded program.\textsuperscript{326}

The court also addressed the defendants' argument that Vadnais was not "otherwise qualified" for elective ear surgery.\textsuperscript{327} Initially, the court noted that it was appropriate for the defendants to consider Vadnais's disability in determining whether he was "otherwise qualified" for surgery.\textsuperscript{328} Citing \textit{School Board v. Arline},\textsuperscript{329} it stated that the defendant hospital could take into account the risks imposed on both the patient and the hospital by the prospect of performing surgery on an HIV-positive patient.\textsuperscript{330} If they concluded that risks existed, they needed to consider whether it was possible to make reasonable accommodations to enable the surgery to be performed.\textsuperscript{331} Following \textit{Arline}'s mandate, the court needed to make "an individualized inquiry and appropriate findings of fact" in making the "otherwise qualified" determination.\textsuperscript{332} Here, the facts were in dispute regarding the risks of surgery.\textsuperscript{333} However, based on the plaintiff's evidence, enough facts supported the conclusion that Vadnais was "otherwise qualified" for surgery.\textsuperscript{334} Additionally, the defendants failed to produce any evidence that reasonable accommodations were impossible to make.\textsuperscript{335}

The court acknowledged that there was merit in the defendants'
argument that a court should defer to a physician's medical judgment, again relying on Arline. However, accepting this argument at face value would render section 504 powerless to prevent discrimination in the health care area. The court concluded that the appropriate approach was the one discussed in Pushkin v. Regents of the University of Colorado, where deference to medical opinion was balanced against the detection of discriminatory motives.

The Glanz court held that because the receipt of Medicare and Medicaid payments brought Beth Israel within section 504 coverage, and because there were genuine issues of material fact regarding the "otherwise qualified" inquiry, summary judgment could not be granted in favor of Beth Israel.

As the previous discussion points out, the growth of the AIDS epidemic has engendered ethical and legal problems stemming from the reluctance of some health care workers to treat HIV-positive individuals. One means by which these individuals may vindicate their rights is through section 504. Accumulated case law demonstrates how courts have approached a cause of action alleging discrimination on the basis of disability.

It is clear that an individual alleging a violation of his rights under section 504 has a private cause of action and may seek money damages. In situations involving health care providers, Medicare and Medicaid payments constitute receipt of federal financial assistance for the statute's purposes. Regarding the scope of section 504's coverage, the antidiscrimination prohibitions extend to an entire institution if any part of it receives federal financial assistance. However, coverage is limited to those programs or activities that actually receive the financial assistance.

Additionally, the doctrine of respondeat superior is applicable to a section 504 cause of action. Therefore, a hospital may be vicariously liable for the discriminatory acts of its physician-employees, and under certain circumstances, for its physician-independent contractors. An individual who has been discriminated against on the basis of his HIV-positive status may bring a section 504 cause of action, since HIV-positive status qualifies as a handicap or disability under

336. Id.
337. Id.
338. 658 F.2d 1372 (10th Cir. 1981).
339. Glanz, 756 F. Supp. at 638. See supra note 129 and accompanying text (quoting Pushkin's standards regarding the burden of proof for § 504 actions).
the Act. However, one of the most important factors in determining whether the plaintiff will be successful lies in the application of the four-part Arline test to determine whether he is "otherwise" qualified for participation in the federally funded program or activity. All these factors are essential considerations in determining who may be liable when a physician refuses to treat an HIV-positive patient.

II. Analysis

This analysis addresses the areas of law previously discussed in relation to a physician's refusal to continue treating an individual because of that individual's HIV-positive status. Part A addresses the situation's ethical aspects, and Part B addresses the mechanics of bringing a cause of action under section 504. Part C then discusses the determination of who may bring suit under the Act, and the three elements involved in making that determination. Part D addresses the cases and legislation which define the scope of section 504's coverage. Part E applies the theories of vicarious liability to hospitals, while Part F addresses the doctrine of respondeat superior as applied to section 504 actions. Part G discusses the Glanz v. Vernick decision and addresses that court's interpretation of previous case law as applied to the facts of the case. Finally, Part H applies the analysis to two hypothetical situations involving a physician's discrimination against an HIV-positive individual and a hospital's potential liability for the physician's acts.

A. Issue of Whether There Is an Ethical Obligation to Treat

The AIDS epidemic has caused ethical and legal dilemmas of enormous proportions. Although many medical associations have stated that a physician has an ethical obligation to not refuse treatment to an individual solely on the basis of his or her HIV-positive status, some medical associations have refused to take this position.341 The problem is exacerbated by the fact that, although the risk of occupational infection is low, the risk still exists.342 Additionally, some health care workers may be at a greater risk of infection because of their regular contact with patients' blood and body fluids.

341. See supra notes 54-57 and accompanying text (quoting various medical associations' positions on the ethical duty to treat HIV-positive individuals).
342. See supra notes 38-49 and accompanying text (discussing the risk of occupational infection).
and common use of instruments that may cause cuts and punctures. In response to this increased risk, some health care workers refuse to care for HIV-positive patients for fear of becoming infected themselves. This puts HIV-positive individuals in a position where they may be refused treatment that would normally be available to them if they were HIV-negative. Such discrimination impacts the quality of care that an HIV-positive individual receives. Moreover, this type of discrimination is unique and unlike discrimination on the basis of race, gender, or age. In certain situations, health care workers do run a risk, although extremely slight, of contracting a disease that may impact their employment, their families, and their health.

Although some individuals may use this risk as a rationale to disagree with statements pronouncing ethical obligations to treat, the ultimate legal parameters of the duty to treat are set by the courts through private causes of action brought by HIV-positive individuals alleging discrimination.

B. Bringing a Cause of Action under Section 504

A violation of section 504 occurs when an “otherwise qualified” individual with a disability has been subjected to discrimination under any program receiving federal financial assistance, solely on the basis of his disability. The courts, as discussed in Pushkin v. Regents of the University of Colorado, have determined that a private right of action exists under section 504. The Pushkin court recognized that the purposes of Title VI and Title IX, and by analogy section 504, are “to avoid the use of federal resources to support discriminatory practices” and “to provide individual citizens effective protection against those practices.” Therefore when an individual has been discriminated against by a physician or hospital which receives Medicare or Medicaid, a private right of action may be essential to promote these purposes. HIV-positive individuals rely upon hospitals and physicians for their health care. If such institu-

343. See supra notes 44-46 and accompanying text (indicating that some health care workers are at greater risk than others).
344. See supra notes 47-53 and accompanying text (discussing the reasons some health care workers are refusing to care for AIDS patients).
347. Pushkin, 658 F.2d at 1380.
tions refuse to treat, it is imperative that HIV-positive individuals use the protection afforded them by federal statute to help insure access to the care they need to maintain the best quality and length of life possible.

Support for a private cause of action can be found by applying the Cort test to a section 504 plaintiff who has been discriminated against on the basis of his HIV-positive status. First, the HIV-positive individual is a member of the class which the statute was intended to benefit. An HIV-positive individual fits the description of "individual with handicaps" in the regulations enacted pursuant to section 504 since he has a "physical or mental impairment" as defined in regulations adopted pursuant to the Act. These impairments include physiological disorders of the hemic and lymphatic systems, as well as many of the other listed disorders that occur in the more advanced stages of AIDS.

Second, there is an indication of legislative intent to create a private remedy in such a situation. Congress amended the definition of "individual with handicaps" to provide coverage for a maximum number of individuals. Congress indicated an intent to make this remedy available to a wide range of disabled individuals by patterning section 504 after other antidiscrimination statutes with implied rights of action.

Third, it is consistent with the purpose of the underlying legislative scheme to imply a private cause of action. Title VI, after which section 504 was patterned, and Title IX sought to accomplish two purposes: "to avoid the use of federal resources to support discriminatory practices" and "to provide individual citizens effective protection against those practices." Therefore, by analogy, an HIV-positive individual must have a private right of action under section 504 in order to have effective protection against discrimina-

348. Id. at 1378 (quoting Cort v. Ash, 422 U.S. 66 (1975)).
349. See supra note 118 and accompanying text (stating the first prong of the Cort test).
351. Id.
352. See supra note 118 and accompanying text (stating the second prong of the Cort test).
353. See supra note 84 and accompanying text (discussing the legislative amendment of the definition of "individual with handicaps" and Congress's purpose behind the amendment).
354. See supra text accompanying notes 121-24, 190 (discussing the relationship between Title VI, Title IX, and § 504). See also supra text accompanying notes 109-17 (discussing the Pushkin court's analysis of § 504's legislative history).
355. See Pushkin v. Regents of the Univ. of Col., 658 F.2d 1372, 1378 (10th Cir. 1991).
356. Id. at 1380.
tory practices. 357

The prohibition of discrimination on the basis of disability is not "traditionally relegated to state law." 358 Title VI and Title IX are federal statutes that prohibit discrimination in federally funded programs. 359 Clearly, where HIV-positive individuals have been discriminated against in the context of a federally funded program, they could satisfy all the requirements of the Cort test.

The important issue of whether damages could be awarded to a section 504 plaintiff was addressed in Miener v. Missouri. 360 In determining that a damage remedy was available to the plaintiff who suffered from serious learning disabilities, the court extended a substantial means of redress to victims of handicap discrimination. 361 The court looked at case law, legislative history, and the effectiveness of other available remedies in its analysis. 362 The Miener court recognized the principle enunciated by the Supreme Court that where legal rights are invaded, and a federal statute provides a right to sue, federal courts may use any available remedy to correct the wrong. 363 As the Miener court recognized, administrative enforcement remedies provided for by the Act are inadequate to vindicate individual rights. 364 This is an important factor when there has been discrimination against an AIDS patient who brings suit under the Act, but who may not have lived long enough for an injunctive remedy to have any worth. Money damages may be the only means of providing some compensation for the families of AIDS victims. Such families are often stretched to the limit financially, physically, and emotionally in trying to care for the dying individual. Additionally, money damages may provide the only effective deterrent to discriminatory practices.

C. Determining Who May Bring Suit under the Act

Three essential requirements must be met for a plaintiff to bring
suit under section 504: (1) the individual must be "handicapped" within the meaning of the Act; (2) the individual must be "otherwise qualified" within the meaning of the Act; and (3) the discrimination must occur within a federally funded program. These requirements will be addressed separately.

1. The Individual Must Be "Handicapped" within the Meaning of the Act

Deciding whether an individual qualifies as disabled is a threshold issue in determining who has standing to sue under the Act. It was not until School Board v. Arline that the United States Supreme Court extended the protection of the Rehabilitation Act to include communicable diseases. Although the Court expressly declined to decide the issue of whether HIV-positive persons could be considered disabled under the Act, the decision was nevertheless a significant step towards applying the Act to HIV-positive individuals.

One important aspect of Arline is that the Court stated that a contagious status does not remove an individual from coverage under section 504. Rather, a contagious status figures into the "otherwise qualified" determination that the court must make. This is an important step toward extending the protection of section 504 to those with HIV-positive status. Such individuals will remain contagious as long as they are infected with the disease (i.e., for the remainder of their lives). If the presence of a contagious state disqualified individuals from coverage under the Act, then even the smallest risk of contagion could provide a basis to exclude. Arline makes it clear that an HIV-positive individual's contagious state will not automatically result in exclusion, but instead will be taken into consideration by the court in making an "otherwise qualified" determination.

A second important aspect of Arline is its mandate that the "otherwise qualified" inquiry should include individualized findings of fact regarding four factors: a) the nature of the disease, b) the duration of the disease, c) the severity of the risk, and d) the probability

365. See supra note 80 and accompanying text (quoting the text of § 504).
367. See supra notes 162-63 and accompanying text (discussing Arline's significance in bringing HIV-positive status within the Act's protection).
368. Arline, 480 U.S. at 285-86.
369. Id. at 286-87.
that the disease will be transmitted.\textsuperscript{370} The application of these factors will allow the fact finder to determine whether the disabled individual is, in fact, otherwise qualified to participate in the program or activity. For example, a determination that the severity of the risk and the probability of transmission are both very high could indicate that the individual is \textit{not} otherwise qualified to participate. However, if the severity of the risk is high but the probability of transmission is low, as in the case of occupational exposure to HIV, the individual may be deemed “otherwise qualified.”

Although the Supreme Court expressly declined to include HIV status as a disability under the Act, the following year a federal appellate court applied the \textit{Arline} concepts to HIV status in \textit{Chalk v. United States District Court Central District of California}.\textsuperscript{371} The \textit{Chalk} decision is significant in that it expressly recognized AIDS as a disability under section 504 of the Act.\textsuperscript{372} It is also significant in applying \textit{Arline}'s “otherwise qualified” inquiry to HIV-positive status.\textsuperscript{373}

\section*{2. The Individual Must Be “Otherwise Qualified” within the Meaning of the Act}

The Act prohibits discrimination against “otherwise qualified” individuals with disabilities, in programs or activities receiving federal financial assistance.\textsuperscript{374} In \textit{Arline}, the Supreme Court stated that courts should normally defer to the “reasonable medical judgments” of public health officials in making “otherwise qualified” judgments.\textsuperscript{375} However, this sets up the paradox that was addressed in \textit{Glanz v. Vernick}, where the person making the “medical judgments” is the alleged discriminator.\textsuperscript{376} The \textit{Glanz} court looked to the opinion in \textit{Pushkin v. Regents of the University of Colorado}\textsuperscript{377} to solve this dilemma.\textsuperscript{378}

The \textit{Pushkin} court explained the appropriate approach regarding

\begin{itemize}
\item \textsuperscript{370} See supra note 156 and accompanying text (quoting the Supreme Court's “otherwise qualified” inquiry).
\item \textsuperscript{371} 840 F.2d 701 (9th Cir. 1988).
\item \textsuperscript{372} Id. at 704-05.
\item \textsuperscript{373} Id.
\item \textsuperscript{374} 29 U.S.C. § 794(a) (1988).
\item \textsuperscript{375} School Bd. v. Arline, 480 U.S. 273, 288 (1987).
\item \textsuperscript{377} 658 F.2d 1372 (10th Cir. 1981).
\item \textsuperscript{378} \textit{Glanz}, 756 F. Supp. at 638.
\end{itemize}
the burden of proof. First, the plaintiff must establish a prima facie case by showing that he was an otherwise qualified handicapped person apart from his disability, and that he was rejected under circumstances which gave rise to the inference that his rejection was based solely on his disability.\textsuperscript{379} Once the plaintiff establishes this prima facie case, the defendant has the burden of proving that the plaintiff was \textit{not} otherwise qualified, or in other words, one who is able to meet all of the program's requirements in spite of his disability. The defendant may also prevail by showing that the plaintiff's rejection from the program was for reasons other than his disability.\textsuperscript{380} Finally, the plaintiff has the burden of rebuttal by presenting evidence that the reasons articulated for the rejection, other than the disability, encompass "unjustified consideration of the handicap itself."\textsuperscript{381} It is when the plaintiff shows that the rejection involves "unjustified consideration" of the disability that he can overcome the deference that would otherwise be accorded to the discriminating physician's medical determination.\textsuperscript{382} In an AIDS discrimination situation, this could presumably be done by presenting expert witness evidence that reasonable accommodations could have been made to allow the plaintiff to participate in the program or activity.

3. \textit{The Discrimination Must Occur within a Federally Funded Program}

Another important issue in fixing liability under the Act is determining which programs qualify as federally funded. The court in \textit{United States v. Baylor University Medical Center} found that a hospital's receipt of Medicare and Medicaid payments triggered the coverage of section 504.\textsuperscript{383} This decision has extremely important ramifications for HIV-positive individuals. Most health care facilities and individual physicians receive Medicare/Medicaid payments. Therefore, most health care facilities and individual physicians may be considered federally funded programs. By the nature of the disease, HIV-positive individuals and those with AIDS become extremely dependent on the health care community for quality and

\textsuperscript{379} Pushkin v. Regents of the Univ. of Colo., 658 F.2d 1372, 1387 (10th Cir. 1981).
\textsuperscript{380} Id.
\textsuperscript{381} Id.
\textsuperscript{382} See supra notes 327-39 and accompanying text (discussing the approach taken in \textit{Glanz}, which balances deference to medical opinion with the detection of discriminatory motives).
\textsuperscript{383} 736 F.2d at 1039. See supra notes 178-88 and accompanying text (discussing \textit{Baylor}).
length of life. It is thus essential that these individuals have access to quality health care. To deny them health care on the basis of their HIV-status would contravene the purpose of section 504.

D. Defining the Scope of Section 504's Coverage

When an institution receives federal funding in the form of Medicaid and Medicare, an essential issue is the determination of whether the institution is subjected to the prohibitions of section 504. In Grove City College v. Bell, the Supreme Court held that because some of the students received federal assistance in the form of BEOGs, the college was a recipient of federal financial assistance. However, the Court held that the students' receipt of aid did not subject the whole college to the prohibitions of Title IX. Rather, only Grove City College's financial aid program was subject to the prohibitions of Title IX. In other words, only the specific program receiving the federal assistance was subject to the antidiscrimination provisions.

Congress reacted to the Court's decision by amending the four major civil rights statutes that prohibit discrimination in federally assisted programs, including section 504 of the Rehabilitation Act. Congress added a new section to each of these statutes to make it clear that discrimination is prohibited throughout an entire agency or institution if any part of the agency receives federal financial assistance. Therefore, the scope of section 504 and the other amended statutes should no longer be interpreted as "program-specific."

In the health care context, this means that if a hospital or clinic receives Medicare or Medicaid payments in any one of its programs or activities, the entire institution is subject to section 504's prohibitions. In other words, all the operations of the hospital are within section 504's scope.

The Supreme Court again interpreted the scope of section 504 in

384. BEOG is the acronym for a Basic Educational Opportunity Grant.
386. Id. at 573.
387. Id. at 573-74.
388. Id.
391. See supra note 208 and accompanying text (stating pertinent parts of § 504 as amended by the Civil Rights Restoration Act).
United States Department of Transportation v. Paralyzed Veterans of America, where it held that only those who actually receive federal financial assistance are subject to section 504. The Supreme Court looked at the statute and found that by its language, section 504 limits its coverage to the "program or activity" that "receiv[es]" the federal financial assistance. The Court explained that Congress sought to impose section 504 coverage as an obligation tied to the recipient's agreement to accept the federal funds. Additionally, the Court rejected the argument that the airlines were "indirect recipients" of the aid to airports. In trying to clarify its position, the Court distinguished intended beneficiaries from intended recipients. The Court acknowledged that in Grove City College there was no distinction between direct and indirect aid. However, it explained that these statements were made in the context of determining whom Congress intended to receive the federal money.

Several times in the opinion, the Court indicated that its approach, which differentiated between "intended recipients" and "intended beneficiaries," reflected Congress's intent. However, later that same year, Congress enacted the Air Carrier Access Act to specifically prohibit air carriers from discriminating against disabled individuals in the provision of air transportation. As in the situation after Grove City College, Congress was taking action to expand the coverage of the antidiscrimination provisions which the Supreme Court had narrowed.

In the context of Medicaid and Medicare payments, both physicians and hospitals may be interpreted as the intended recipients of federal financial assistance. In a situation where a physician-employee treats a Medicare patient in a hospital setting, it can be argued that both the physician and the hospital are the intended recipients, even if only one receives the Medicare or Medicaid payment directly.

393. Id. at 604.
394. Id. at 605.
395. Id. at 606.
396. Id.
397. Id.
398. See supra notes 220-26 and accompanying text (discussing the difference between intended recipients and intended beneficiaries).
399. See supra notes 232-33 and accompanying text (explaining the Air Carrier Access Act and a Senate report regarding the purpose of the statute).
E. Applying Vicarious Liability to Hospitals

When a physician refuses to treat an HIV-positive individual in a hospital setting, it is important to address the implications of the doctrine of respondeat superior. Under that doctrine, the hospital may be liable for the acts of a physician whom it employs when such acts occur within the scope of the physician's employment.400 A hospital may also be liable for the acts of a physician who has independent contractor status under the doctrine of apparent or ostensible agency.401 Ostensible agency will apply where the individual patient looked to the hospital to provide him with medical treatment, and where the hospital represented that its physicians would provide that treatment.402

When an HIV-positive individual goes to a hospital and is referred to an independent contractor physician with whom the individual had no prior relationship, a finding of ostensible agency will depend on several factors: whether the individual dealing with the physician believes that the physician is an agent of the hospital, whether the belief is generated by some act on the part of the hospital, and whether or not the HIV-positive individual is guilty of negligence.403

F. Applying the Doctrine of Respondeat Superior to Section 504 Actions

The district court in Patton had to decide whether vicarious liability could be applied to a section 504 suit. It found that the application of respondeat superior would be consistent with the statute's policy of eliminating discrimination against the disabled.404 Such an application would also create an incentive for the employer to exercise care in the "selection, instruction and supervision of his employees."405 The court stated that in the absence of a congressional directive to the contrary, it would assume that Congress intended the courts to use every available tool to eliminate discrimination against

400. See supra notes 249-59 and accompanying text (stating the principles of respondeat superior as applied to hospitals).
401. See supra notes 260-63 and accompanying text (outlining the theory of ostensible agency).
402. See supra notes 261-75 and accompanying text (discussing instances in which ostensible agency may be found).
405. Id.
the disabled in federally funded programs.\textsuperscript{406}

In the context of a hospital's vicarious liability for a physician's acts, \textit{Patton's} policy argument is particularly relevant. Holding a hospital liable for a physician's discriminatory acts which violate section 504 would create an incentive for the hospital to closely supervise the activities of physicians dealing with HIV-positive individuals. This would encourage the hospital to develop policies for treating HIV-positive patients and could potentially improve their quality of care. Additionally, it would provide physicians with a source of information and support regarding medical treatment for HIV-positive patients. It would encourage a hospital to take disciplinary action when a physician's action did not comport with hospital policy regarding HIV-positive individuals.

\textbf{G. The Glanz Decision}

The Massachusetts federal district court in \textit{Glanz v. Vernick} was faced with a situation where a physician, who was an employee of a hospital, allegedly discriminated against a patient when he refused to perform necessary ear surgery after learning that the patient was HIV-positive.\textsuperscript{407} The plaintiff, and later the plaintiff's estate, brought suit alleging a violation of section 504.\textsuperscript{408} After finding that the hospital was a recipient of federal funds because it received Medicare and Medicaid payments, the court analyzed in detail the Supreme Court's opinions in \textit{Grove City College} and \textit{Paralyzed Veterans} to determine whether Dr. Vernick could be held personally liable for allegedly discriminating against the plaintiff.\textsuperscript{409} The court cited \textit{Grove City College} for the proposition that application of the antidiscrimination provisions of civil rights legislation for programs receiving federal funding must be program-specific.\textsuperscript{410} Therefore, the court stated that the application of section 504 was to be "limited to the relevant program receiving the funds."\textsuperscript{411} In this situation, the "relevant program" was the hospital's Ear, Nose and Throat Clinic. Applying \textit{Paralyzed Veterans}, the court reasoned

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406. Id.
408. Glanz, 756 F. Supp. at 634.
409. See supra notes 316-26 and accompanying text (discussing \textit{Glanz} in conjunction with \textit{Grove City College} and \textit{Paralyzed Veterans}).
411. Id.
\end{flushleft}
that Dr. Vernick was an employee of the hospital and therefore did not actually "receive" federal funds while working in that capacity.\textsuperscript{412}

In its analysis, the \textit{Glanz} court applied an interpretation of section 504 that is no longer appropriate since the enactment of the Civil Rights Restoration Act of 1987.\textsuperscript{413} The court did not explain its reasoning, but one possible explanation is that the discriminatory act itself occurred before the passage of amendments that broadened the scope of section 504.\textsuperscript{414} Once the court determined that section 504's prohibitions were limited to the hospital's clinic, the court felt that it could look no further to determine whether Dr. Vernick was a recipient of federal funds.\textsuperscript{415}

However, the court acknowledged that Dr. Vernick participated in another "program," the private medical practice in which he personally received federal funds for treating some patients.\textsuperscript{416} At times, Dr. Vernick treated patients from his personal practice at the hospital.\textsuperscript{417} This practice fits within the Act's definition of a "program or activity."\textsuperscript{418} The amended Act defines a "program or activity" that receives federal funds as "all the operations of ... an entire ... private organization or entire sole proprietorship ... principally engaged in the business of providing ... health care ... any part of which is extended Federal financial assistance."\textsuperscript{419} If the court had applied the broad coverage of the amended version of section 504, the result would have been that section 504's coverage was no longer program-specific. Therefore, since Dr. Vernick's practice fit the definition of program or activity, and since he received federal funds in one program (his own private practice), he would be subject to the statute. This is so even though he did not directly receive federal funding in the context of his employment at

\textsuperscript{412} See supra notes 209-26 and accompanying text (discussing Paralyzed Veterans and the Supreme Court's holding that only those who actually receive federal funds are subject to § 504's coverage).

\textsuperscript{413} See supra notes 205-08 and accompanying text (discussing the Civil Rights Restoration Act).

\textsuperscript{414} See supra note 316 (discussing the time frame of the discriminatory act and passage of the amendment to § 504).

\textsuperscript{415} Glanz, 756 F. Supp. at 637.

\textsuperscript{416} Id.

\textsuperscript{417} Id.

\textsuperscript{418} See supra notes 81-82 and accompanying text (stating the definition of "program or activity").

\textsuperscript{419} 29 U.S.C. § 794 (1988). See supra notes 207-08 and accompanying text (discussing the broad coverage of § 504 as amended by the Civil Rights Restoration Act).
the hospital.

The *Glanz* court went on to find that even though Dr. Vernick was not liable under the statute, the hospital could still be held vicariously liable if it exercised power or control over the professional conduct of the physician.\textsuperscript{420} The court found various factors indicating the requisite control was present and held that the hospital could be held liable for Dr. Vernick's actions based on respondeat superior.\textsuperscript{421} This result is problematic since many cases cite the common law principle that an employer is freed from any liability based on the employee's actions if the court finds that the employee is not liable.\textsuperscript{422} According to this principle, once Dr. Vernick was found not liable under the statute, the hospital could not be held vicariously liable.

A second problem related to holding the hospital, but not the physician, liable is that it relieves the physician of liability even though he discriminated against an HIV-positive patient. According to the dissenting opinion in *Paralyzed Veterans*, the question should be whether the physician is "in a position to 'exclud[e handicapped persons] from the participation in, . . . den[y them] the benefits of, . . . or subjec[t them] to discrimination under' a program or activity receiving federal financial assistance."\textsuperscript{423} It is the physician who is in a position to deny treatment to the HIV-disabled individual. Under the dissent's rationale, the physician himself is the "program" that should be subject to section 504's prohibitions.

Another factor to consider is that the majority in *Paralyzed Veterans* strongly emphasized the difference between "recipients" and "beneficiaries" and stated that the statute's prohibitions were limited to Congress's "intended recipients" of federal funds.\textsuperscript{424} Here, both physicians and hospitals are the intended recipients of Medicare and Medicaid payments.

In summary, a more equitable result would be obtained in this situation if physicians were held personally liable for their discriminatory acts. This would remove the inconsistency of holding the hos-


\textsuperscript{421} See supra notes 303-07 and accompanying text (discussing the factors dispositive for the court in finding vicarious liability).

\textsuperscript{422} See supra notes 246-48 and accompanying text (stating the effect of an employee's non-liability upon vicarious liability of the employer).


\textsuperscript{424} Id. at 606-07.
pital, but not the physician, liable under section 504.

I. Applying the Analysis to Hypothetical Situations

Incorporating the previous analysis, the following sections of this Comment address two hypothetical situations where, in a hospital setting, a physician refuses to continue treating an HIV-positive individual.

1. Hypothetical Involving a Physician-Employee

In the first scenario, the physician is an employee of the hospital and has no independent practice of his own. He receives no Medicare or Medicaid payment for his work but simply receives a salary from the hospital. An HIV-positive patient comes to the hospital or clinic for treatment and is referred to the physician. The patient and the physician have no previous relationship independent of the hospital.

In this situation, the physician does not fit section 504's definition of "program or activity." Since he has no independent practice and is simply an employee, he is not a corporation, partnership, private organization, or sole proprietorship. Additionally, he does not "receive" federal funding in the form of Medicaid or Medicare. It is doubtful whether he would be held liable under the Act.

However, it could be argued that the hospital should be held directly (not vicariously) liable for allowing its employee to act in a discriminatory manner towards an HIV-positive patient who was treated in the hospital's facilities. The hospital itself would fit the definition of "program or activity" and would be a recipient of federal funds since it receives the Medicare or Medicaid directly.

2. Hypothetical Involving a Physician-Independent Contractor

In the second scenario, the physician is not an employee of the hospital, but instead has independent contractor status. As in the first hypothetical, the HIV-positive individual comes to the hospital or clinic seeking treatment and is referred to the physician. The

425. See supra note 81 and accompanying text (stating the definition of "program or activity").
426. See supra notes 178-88 and accompanying text (discussing the rationale for finding that Medicare and Medicaid constitute federal financial assistance).
427. See supra notes 81 and 180 and accompanying text (defining "program or activity" and stating that Medicare and Medicaid constitute federal financial assistance).
physician refuses to treat him after determining his HIV-positive status.

In a situation where the physician receives the Medicare or Medicaid payments himself, he would clearly be the recipient of federal funding and would be within the scope of section 504. The court should consider various factors to determine whether the physician has independent contractor status, or whether the hospital exerts such control that vicarious liability would be appropriate. Factors indicating control include instances where the hospital: determines the physician’s schedule; establishes policies and procedures to be followed by the physician; pays the physician’s wages, provides equipment, supplies, and office space; and bills patients for the physician’s services.

However, even if the physician is found to have independent contractor status, the hospital may still be held liable under the theory of ostensible agency. Ostensible agency applies where the hospital “holds out” to patients that physicians associated with it are its employees, or where the hospital “holds out” to its patients that it is a provider of medical services, and the patient goes to that hospital relying on it to deliver those medical services. The Glanz court stated that, because of the policy discussed in Patton, it would be appropriate to hold a hospital responsible for the actions of its medical staff regarding compliance with the Act, even without a finding of power or control. This further suggests that independent contractor status will not necessarily preclude a hospital’s liability for the acts of its physicians.

CONCLUSION

Persons who test HIV-positive are disabled persons protected by the nondiscrimination prohibitions of section 504 of the Rehabilitation Act. Most public and private health care providers in the

428. See United States Dep't of Transp. v. Paralyzed Veterans of Am., 477 U.S. 597, 605 (1986) (holding that § 504's coverage is limited to those who actually receive federal financial assistance).
429. Hodson, supra note 249, at 245.
430. See supra note 251-59 and accompanying text (discussing factors the court considers in assessing whether a hospital may be liable for the negligence of a physician functioning as an independent contractor).
431. See supra notes 260-63 and accompanying text (discussing the doctrine of ostensible agency).
United States are recipients of federal financial assistance in the form of Medicare and Medicaid. As such, they are prohibited from discriminating against persons who have the AIDS virus. Refusal to provide health care services to such individuals violates the antidiscrimination guarantees of section 504.

However, in demanding equal treatment for HIV-positive individuals, the courts are dealing with a situation that some health care providers view as jeopardizing not only their livelihoods, but also their lives. It will take time and education to successfully ensure nondiscriminatory treatment for all HIV-positive individuals.

Nancy A. Moore